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ABSTRACT

This document contains 19 papers from the ninth World Conference of Therapeutic Communities (TCs) that deal with the interface between the mental health establishments and the TC. Papers include: (1) "Psychiatry and the TC" (Jerome Jaffe); (2) "The Chemical Brain" (Sidney Cohen); (3) "Where Does the TC Fail?" (Ab Koster); (4) "Psychiatric Severity and Response to Treatment in a TC" (Sherry Holland); (5) "Psychiatric Disorder in TC Admissions" (Nancy Jainchill and George De Leon); (6) "Diagnosis & Treatment of the Dual Diagnosis Client" (H. L. Wilder and Christopher Dawson); (7) "The Use of Psychiatric Medications in a Drug Free TC" (Joe Lamberti and Anne Blyth); (8) "A Multi-Modality Approach to Treatment in a TC" (Robert Vaughn Frye); (9) "Working with Minorities in the TC" (Arnold Abbott); (10) "The Group Process within the Context of the TC" (Eugene Adler); (11) "Addict Rage: A Therapeutic Dilemma" (Evan Garelle); (12) "Leaving the TC: Fantasies and Emotions" (Eliseo M. Gonzalez Regadas); (13) "The Role of Art as a Therapeutic Tool" (Sue Ann Rizzo); (14) "Towards an Ethics of the TC Model in the Approach to the Addicted Patient" (Daniel A. Campagna); (15) "A Rehabilitation Program in Brazil" (Haroldo J. Rahm); (16) "Reflections on Gradiva TC in Argentina" (Juan Alberto Yaria); (17) "The Sopimusvuori Society: A System of Rehabilitation in Finland" (Markuu Ojanen); (18) "A.R.E.B.A.-Casriel Institute: A Different TC" (Pietro Ceriana); and (19) "Applications of Gestalt Therapy in the TC" (Joan Zweben). (NB)

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CHAPTER 5

MENTAL HEALTH AND THE TC

PSYCHIATRY & THE TC

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I can't recall a time when I wrote a speech for someone else to present. I have difficulty imagining how these words will sound coming from someone else's lips. If, at times, the words sound overly sentimental - forgive the speaker; it is the writer who has stepped over the bounds of formality to speak to old friends and to express regret at missing an opportunity to meet the new generation of leaders in the world of T.C.s.

I wanted very much to be with you at this meeting, because there were so many old friendships that I wanted to renew and so many faces that I wanted to see again. I knew that there would be at this meeting old comrades from the early battles to establish the validity of the T.C. as an effective intervention, not only for problems of addiction, but also for problems of character and behavior unrelated to drug abuse. I have many vivid memories of those early struggles, and I must admit they grow fonder with the years.

It has been more then 20 years since I first visited Synanon and Daytop Village and became aware of a remarkable and innovative concept that was certain to have an profound impact not only on the treatment of addiction, but on the fields of psychiatry, criminal justice, and sociology, as well. At the time, I was a junior faculty member in psychiatry at a medical school in New York. Unlike some of you who have grown up with the therapeutic community movement, I have had a number of very different roles over the intervening twenty years. They have at various times involved research and teaching at medical schools, consulting with government and private industry, and developing and running programs related to drug addiction at both State and National levels. From time to time, some of the titles of the positions were far more impressive than I would have wanted. I have never felt comfortable with titles and formality. Perhaps that is why I felt at home in therapeutic communities where, in the early days, you knew that last week's new entry could be next year's facility director. The quality resided in the person, not in the credentials or the title. Today, I am temporarily wearing one of those formal hats again: Acting Director of the National Institute on Drug Abuse. I hope that you will not let your image of that role color what I plan to say here - for I do not speak so much as the Acting Director of NIDA, but as a long time observer of the field and as a long term friend of the therapeutic community concept.

I want to speak of old friendships, old tensions, and new challenges.

OLD FRIENDSHIPS - because it is only upon trust and human relation ships that individual organizations can thrive, and only when there are such relationships that different organizations can work together effectively.

OLD TENSIONS - because the therapeutic communities grew up in an atmosphere when they were often looked upon with skepticism by researchers and mental health professionals, and in which they, in turn, went to great lengths to criticize and often to exclude or minimize the contributions that such professionals and a research orientation could make.

NEW CHALLENGES - because we must recognize that new findings about the co-existence of addictions and other forms of mental illness cannot be forever ignored and because a deadly new virus - the AIDS virus - has emerged and is spreading rapidly among the drug abusers that the therapeutic communities were created to help.

OLD FRIENDSHIPS: Some of my fondest memories of the past 20 years are of the times I spent at Gateway House in Chicago. It wasn't always known as Gateway - but that is a story for another time. Had Synanon been more willing to establish a facility in Chicago, Gateway might never have come into existence. Nor was Daytop Village at the time, 1967, ready to open a facility that far from its home base. But in 1966, when the planning for treatment programs in Illinois began, I felt that a therapeutic community had to be part of that plan. Daytop was a key element in the establishment of Gateway. Patients I saw in Chicago in 1967 were sent to Daytop in New York with the hope that they could learn enough to develop a facility in

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Illinois when they returned. (Some of those patients have since gone on to graduate from professional schools and to enter government at high levels.)

I remember, too, the problems we had in finding the resources and the location for such a facility. Neighbors were wary; use of a house as a Therapeutic Community violated zoning laws. The State of Illinois would not let its funds be used to purchase real estate, and no one would give a mortgage to the fledgling Gateway House Foundation which had no assets and no income. At one point, I became personally liable for the mortgage on one of Gateway's early facilities, much to the dismay of my family, who had images of bank foreclosures and furniture on sidewalks.

But, the return on the investment was greater than any I have made. While I lost some money, I got to know the people who made the system work. My children, my wife, Faith, and I felt at home at Gateway; Gateway even adopted our kittens.

By that time, there had been a change in the organizational structure at Daytop in New York. Key staff members left the organization, just at a time when Illinois was expanding its commitment to treatment, including therapeutic community. We were lucky. David Deitch, Carl Charnett, Michael D'Arcy, Ellen Afterman, Jeanne Peake, Mickey McCallup, and several others were willing to come to Illinois to teach others and to help build the system. Those were days filled with the excitement of a new enterprise. They were also days in which the rivalry between T.C.s and other treatment methodologies that seemed so strident and bitter on the East Coast were far less apparent in Illinois. Instead, there was a willingness to see a role for a range of treatment efforts and for a range of skills including those of physicians, psychologists, and psychiatrists. Early in Gateway's history, a resident psychiatrist I was supervising spent part of his elective time living at the facility.

Fortunately for me, my close friendships with leaders of any one therapeutic community have never interfered (as far as I could tell) with my associations with many of the other pioneers in this field - Monsignor O'Brien, Dan Casriel, Mitch Rosenthal, George DeLeon, Judianne Densen-Gerber - to name only a few. Most have forgiven me for continuing to see a useful role for pharmacological approaches to treatment.

OLD TENSIONS:- The antiprofessionalism - especially the anti- psychiatry bias - of the early years may already be part of the past. If it is, there is no need to dwell on that part of the past. If such feeling persist, however, it will become increasingly necessary to address them, for the challenges to the Therapeutic Communities, at least as I see them, are three-fold:

First: How to deal with a health-care system that is increasingly concerned with costs and is focusing ever more closely on the mental health, drug, and alcohol in-patient sector as an area where savings can be achieved. Second: how to deal with one of the major research findings of the past decade - that most drug abusers have experienced substantial degrees of psychopathology in addition to their problems with drugs and alcohol, and that the severity of these problems has a major influence on how they respond to treatment. Third: How to deal with AIDS.

I will not deal the first; I promised to discuss the second; and I feel obliged to touch upon the third.

The notion that those who become dependent on drugs have other psychiatric; problems is not new. Lawrence Kolb, who studied morphine and heroin addicts in the 1920, clearly described the many psychiatry problems he found. It was not the assertion that additional problems were present that created difficulties between general psychiatry and those who specialized in problems of addition. What usually caused to difficulties was that many in the mental health field were used to looking for the "underlying problem." They leaped too quickly to the view that if only they could treat successfully the "underlying" depression, anxiety, rage, neurosis, or what have you, the drug problem which was assumed to be a symptom of that underlying disorder would go away on its own. For the most part, those mental health professionals who dealt with drug users on the basis of this assumption were not successful. Too often, their lack of success did little to persuade them to re-examine the assumption. Too often, they assumed that what was needed was merely more psychotherapy or psychotherapy under conditions of confinement, involuntary, if need be.

In contrast, when the therapeutic communities emerged and demonstrated, as had AA before them, that drug and alcohol problems could be treated and often "cured" without dealing with any concerns about underlying psychopathology, seeds were sown that grew into a disregard for both the presence and the significance of any co- existing mental problems. This disregard was given further momentum by some of those who advocated the use of methadone maintenance. Observing what they considered to be dramatic decreases in antisocial behavior and increased productive behavior in their early patients, they concluded that most, if not all, of the character problems attributed to addicts were a result of their addiction, not the

cause of it. Furthermore, they believed that once the addiction was controlled, the addicts would require jobs and rehabilitation, but not necessarily psychiatric or psychological help, to become productive citizens.

For about five years, there was no significant challenge to these views. The depression known to be prevalent among drug users and the high suicide rate were generally attributed to the consequences of drug use and drug-using life style. Then things began to change. Researchers, first those working with patients in methadone programs, began to report that symptoms of depression were far more common than among the general population, and that while many patients improved after entering treatment, others did not and some got worse. Further, some developed alcoholism that was not previously prominent. Over the course of a few years, these observations were repeatedly confirmed. Then there was a further development - a technological innovation. Psychiatrists became more objective and more precise in the way they used psychiatric terms and diagnosed psychiatric disorders. They began to use specific criteria, instead of leaving the diagnosis to each practictioner who matched the patients symptoms against his or her impression of what constituted a particular illness. These diagnostic criteria evolved into a revised diagnostic manual for the field, more popularly know as DSM-III. This manual contains diagnostic criteria for a wide range of psychiatric disorders, from schizophrenia to phobia, and from depression to anti-social personality.

When the criteria were used and applied to interviews with drug users entering treatment in a number of different types of programs, it became apparent that it was rare to find drug dependence without some other accompanying syndrome or personality disorder.

One distinction needs emphasis. Not everyone who has ever been depressed is depressed all the time. Therefore, for some illnesses, such as depression, panic disorder, phobia, and schizophrenia, there is a distinction between lifetime prevalence - (how many patients have ever had a disorder), and current prevalence - (how many have the disorder at the time of interview).

Lifetime prevalence is always higher than current prevalence. Note how common some of these disorders are. For example, the lifetime prevalence of any affective or mood disorder is almost sixty percent. Only a minority of addicts entering treatment are free of all diagnosable psychiatric disorders apart from drug dependence.

What is not shown is that multiple diagnoses are not only possible, but common. Thus, drug abuse, alcoholism, depression, and antisocial personality frequently coexist.

The same general pattern of coexistence of drug dependence and psychiatric disorders was seen among a Veterans' population by the research group in Philadelphia headed by O'Brien, McClellan, Woody and coworkers. More importantly, the group has found that the severity of psychiatric difficulties is the single most powerful predictor of outcome across a range of treatment programs, including therapeutic communities. Those with minimal severity of symptoms tended to do well in all programs; those who had most severe problems tended to do poorly no matter what program they entered.

The Philadelphia group also developed a scale, called the Addiction Severity Index, which measured the severity of a number of problems, including legal, family, work, as well as mental health. Overall, Severity scores on this questionnaire, which is rather easy to use, also predict outcome across the range of treatment programs.

This research group also has shown - (and their careful work has generated both attention and controversy) - that within the context of a methadone program, psychotherapy can improve the bleak outlook for those who have the most severe psychiatric problems. I want to emphasize that the work did not directly compare drug counseling to psychotherapy; it compared psychotherapy plus counseling to counseling alone.

Beyond this one finding, it is not clear just how to respond to the now repeatedly confirmed finding of psychopathology among treated drug abusers.

Depression is common among drug users entering all types of programs, including T.C.s. In a large percentage of patients, the depression gets better on its own, but about 20 to 30% remain symptomatic. Some researchers have tried various antidepressants, but thus far the results are disappointing.

At present, no one can say whether psychotherapy is the only way to improve the outlook for those with severe psychopathology in methadone programs, or whether indeed the findings from the Philadelphia group hold for more traditional T.C.s that do not primarily serve veterans; nor can we even say whether all types of psychiatric disorders imply an equally reduced outlook for success in treatment, or whether they effect equally the likelihood of relapse.

In short - you've heard this before, - more research is needed. What is not likely to go away is the fact that most drug abusers have Psychiatric or emotional problems apart from their drug dependence. Should Therapeutic Communities be asking whether such diagnoses or their severity affect the likelihood of doing well? I think that they should. I think that there may come a time, as Therapeutic Communities adopt more procedures used in traditional health care facilities in order to get more regular financial support, that they may be expected to consider such factors - if not be government agencies or third party payors, then eventually by the lawyers who undoubtedly will discover that T.C.s, like doctors, hospitals, and other treatment facilities, can be sued.

I want to turn now, only briefly, to the subject of Acquired Immune Deficiency Syndrome, or AIDS. In my view, the emergence of this fatal viral illness will have a more profound adverse effect on the lives of drug users and those of us who work with drug dependent patients than any single development in our lifetime.

The AIDS syndrome was first described among homosexual men in 1981. It was then noted to be prevalent among IV drug abusers as well. It was suspected early that the syndrome was caused by a virus that can be transmitted from one person to another. That suspicion has been confirmed and a specific virus, called Human T-cell leukotrophic virus type III, or HTLV-III has been isolated. The virus is found in a number of body fluids, - blood, semen, saliva, and tears, - and can be transmitted by intimate sexual contact, by receiving infected blood, or by sharing needles with someone who has the virus. Official statistics which indicate that AIDS is primarily a problem of homosexual men underestimate the significance of IV drug use. Further, in some parts of the country, 50% of AIDS cases are found among IV drug users.

Thus far, 3,000 IV drug users have died of AIDS. It is estimated that an additional 50 to 100 thousand individuals have been exposed to the virus - anywhere from 25% to 50% of these are IV drug users; 10% of those exposed will probably die over the next year.

How will the Therapeutic Communities handle an active case of AIDS? Should all applicants be screened for AIDS virus? Should those who are positive be excluded, segregated, or isolated? Do we need special Therapeutic Communities for those with AIDS? I may be wrong, but I suspect that those who develop AIDS may lose most of their motivation to undertake a major change in lifestyle. But that might be a mistake. It may be that it is repeated exposure that overcomes the body's resistance. In any event, when a T.C. operates like a family, it will be hard to force out a family member who develops a serious illness, no matter how frightening.

No one can predict what the future of the AIDS epidemic will be. I can tell you this, however. Over the past four months, no issue has been given higher priority at NIDA than AIDS. NIDA plans to do far more to tell workers in the field what we know about AIDS and what they can do to reduce the spread of the disease, to ease the troubles of those who have it and to safeguard those who don't. We would like to use the new blood test to find those exposed to the virus but not yet exhibiting the syndrome. We want to know what influence drug use has on further weakening resistance to the virus. We want to know what kinds of messages and appeals motivate those with AIDS to reduce the kinds of contact that give it to others. In short, since we have as yet no treatment and no cure, our only hope lies in finding ways to slow its spread.

NIDA no longer has the responsibility or the resources to fund a frontal attack on this new threat. But we do have responsibility to fund research that will be useful to all of you on the battle lines. We will try within the limits of our resources to meet that responsibility, but NIDA has no special expertise in knowing what messages or techniques work. We need your ideas. We need the old partnership to work again.

It may be necessary to fight the battle on two fronts: one against AIDS among those we wish to help; another to convince the larger society that unless they provide timely support, the epidemic may spill over form the drug using population and the homosexual community to the general population.

It is said that friendships formed in the foxhole last a lifetime. Together, we have been in battle before. Let us go into the new battle, together again.

THE CHEMICAL BRAIN

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As you see from the program, I was supposed to speak here for a few minutes on the chemical brain and if it may seem obscure to you why people in a therapeutic community should be exposed to such a talk, I offer as a background from what is going on in the micro universe of the skull within the skull to what you're doing in the macro universe of real humans and groups of humans.

There are analogies between the chemical processes that are being uncovered that go on in the head with those impacts that you deal with -- emotional, cognitive, perceptual -- in the world that you practice in. Both affect each system. Each affects each other. There is feedback from an experience in a therapeutic community to the microprocessing of chemicals that goes on in the head and visa versa. So you should know a little bit a these exciting developments that are going on regarding chemicals in the brain.

At one time, perhaps 50 years ago, the brain was considered like a piece of Jello. There was just a lot of goopy stuff without even thinking of specificity. We now know that this is completely untrue, that there are specific areas with specific activities, and that each area or group of areas has a chemical specificity. Many transmitters, neurotransmitters, have been uncovered over the past 15 years, and we have obtained significant new knowledge about the chemistry of the brain.

These neurotransmitters do important things. The nerve cells of the brain transmit their signals electrically until they get to the end of the nerve cell or where it hooks up with another nerve cell at the synapse. At that point, the transmission becomes chemical and the chemistry of the brain causes either an enhancement or a subtraction of the signal. The synapse is a control point which has developed somehow so that it can say "Go" and produce an effect or "No, don't go" and inhibit the effect. It is enormously complex -- so complex that I couldn't possibly explain it in the time I have here even if I could explain it.

All our psychotherapeutic drugs are based on moderating what is happening at this interface between nerve cells at the synapse. A class of chemicals has been discovered called endorphins and encephalons. These are the internal narcotics, if you will. They don't look like morphine or any of the narcotics that are external to the body, but they are received in places in the brain called receptor sites, which are identical with those places where opiates are received and produce very similar or identical effects. Relief of pain is the one we think of immediately, but also they have enormous potential, apparently, for changing emotionality.

I do want to specifically talk about one such neurotransmitter as an example of what goes on in the head. I want to say something about the dopamine system. Dopamine is an important neurotransmitter in many parts of the brain. In fact, the disease we call schizophrenia is supposed to be due to increased dopamine activity in certain specific parts of the mid-brain. And, as you might expect, the treatments, the drug treatments of schizophrenia -- so called antipsychotic drugs like Thorazine, Haldol, and so forth -- have many actions, but their important action is that they inhibit or they block the dopamine receptor points causing this surge of dopamine that clinically we call schizophrenia to be to be reduced so that a few schizophrenics can really be called cured if they are given these drugs early enough. For chronic schizophrenics -- the story is different.

So that is one part of the dopamine story, but there are many others. Consider our present concern with cocaine, for example. How does cocaine act in the brain? It appears that what cocaine does is to stimulate the reinforcing centers or pleasure centers of the brain. Cocaine blocks dopamine from being transmitted at the synapse and causes a surge of elation, high, ecstasy, whatever you want to call it, that is associated with the use of cocaine, especially with the intravenous use of cocaine. This is the immediate, powerful, positive emotional state that causes it to be so attracting to so many people over time. So by the allegedly simple action of not allowing the dopamine to be drawn back into the cells from which is was discharged or fired, the dopamine causes a brief but very impressive stimulation of the reward centers of the brain.

How can we deal with such a situation? Well, we can deal with it on a chemical or non-chemical basis. On a chemical basis one can think of blockading that area of the dopamine receptors. This has been tried with anti-depressants. We could think of using a dopamine stimulator which does not cause euphoria and this has been experimented with briefly. We can think of somehow reducing availability of cocaine, and there are no good thoughts that I know of in this regard. But as you are developing your tricks and techniques, so also are the chemists trying to develop theirs to somehow help in dealing with the problem of cocaine.

And I might say that in all respects amphetamines do very similar things as cocaine. Just why cocaine is so popular at the moment and amphetamines not so popular I am not sure, especially when they are both used intravenously. The only difference seems to be that the amphetamine glow lasts longer. Otherwise, descriptively, these are very similar chemicals acting very similarly, interacting with the dopamine system, as I have suggested.

Well, this is a small piece of a great story, and I think it's necessary for you to be aware of what is going on in the world of the microscope, of molecular chemistry, and I have given you a little bit of a background on this amazing organ we have inside of our skulls. What surprises me as much as anything is the fact that we have this enormously almost indescribable instrument up there and yet so many of us try to alter it with substances of dubious purity and unknown quality. The brain is a very precious instrument. I think you would agree with me from your perspective. But as one tries to understand it on the cellular level, it's just as amazing.

WHERE DOES THE TC FAIL?

Ab Koster, Ph.D.

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Before entering into the merits of this theme, let me emphasize that I am a firm believer in the TC model, and that I consider the TC to be a vast contributor in the field of mental health. Still, I feel it to be necessary to evaluate the shortcomings of TC's in general, not so much in an attempt to pass a verdict on the TC concept, as to remain aware of the fact that no model or methodololgy, whether we talk about hierarchical TC's, democratic ones, methadone maintenance programs, daycare facilities, or whatever other flavors we have produced over the last few decades, is able to give the sole answer to the problem of drug addiction.

For the purpose of this session I would like to share with you four points of criticism, that hopefully we'll be subject to discussion in the special interest sessions that are scheduled for the next few days.

1) TC's are not realistic when supposing that they can treat almost any addict, provided that they are motivated for treatment and that they don't suffer from severe mental or physical disturbances.

2) TC's tend to misinform prospective residents by raising unrealistically high expectations about treatment outcomes. This misinformation can be hazardous because casualties can be the result of it.

3) TC's are not sufficiently aware of the fact that a number of dropouts have to be considered casualties as a consequence of the treatment they went through.

4) TC's do not take enough responsibility for those who dropped out and became casualties.

Of course I am aware of the fact that these points of criticism do not equally apply to every program represented here, still I feel that although the problem of dropping out is subject to many research programs and has the undivided attention of many staff members, the problem of producing casualties is underestimated by virtually everybody.

Let us get into this subject a little deeper. I remember that during the first couple of conferences that we held, we tried to determine the unique aspects of the TC, compared to the general field of mental health. We came up with some essential distinctions between the TC model and the traditional forms of therapy: deprofessionalization (breaking out of the traditional doctor-patient relationships) and humanization (acknowledging the tremendous importance of concepts such as role modeling, self help, peer pressure, confrontation, ritual participation, etc.). However, another way of describing the uniqueness of the TC is by saying that a TC is a system of interpersonal relations and that it holds its power at these relations which are a prerequisite for allowing personal growth and self-reliance of any individual member. This partial definition uncovers at the same time one of the main shortcomings of the TC model: those individuals who are, for any kind of reason, not able to relate adequately to others can evidently not be treated successfully in such a setting. Unless selection criteria are used to identify these individuals, many of them will drop out disappointed and without any relevant learning experience. This fact is generally agreed upon by most of todays TCs and so we find a number of exclusions such as:

----individuals with serious extensive histories of mental illness

----severely retarded individuals

----extremely violent and aggressive individuals

----individuals who suffer from organic brain damage

Apart from these, more generally accepted cases, it is surprising how many contradictory notions we find in literature bout this subject. Criteria for exclusion that are equally employed and repudiated include conditions as homosexuality, extreme narcissism, depression, hypochondria, etc.

Most of these criteria mount to the same thing: they try to exclude individuals who are not able to be part in the main task of the community as they adopt an interpersonal role that is harmful for themselves as well as for the other members in the TC. By excluding these categories we try to maintain an optimum therapeutic climate and to reduce the number of drop-outs.

Nevertheless, we still have to deal with a considerable drop-out rate. Dropping out of the program apparently is as much a characteristic feature of the TC system as is, for instance, the self- help concept. A lot of research has been done over the last few years into the causes of this phenomenon. Some of the results can be very helpful in refining the selection process. However, I have the impression that many programs so not use the data available. Many TC's that I know still suffer from megalomania in the sense that they believe to be capable of treating almost any addict. This arrogance is dangerous and can be harmful, not so much for the resident who finishes the program as for the ones who drop out and are liable to get into even bigger trouble than they were before admittance.

In this context, the study of Liebermann, Yalom and Miles on encounter groups is mentionable. They pointed out very clearly that casualties actually occur as a result of treatment. There is every reason to believe that unintentionally and unwittingly, TCs have the same problem as the groups described in this study. At this moment I am researching this problem for my own program and I have to say that some of the preliminary results are rather shocking.

Let me give you one example that you will probably recognize very well. Some residents who drop out appear to turn into real missionaries who try to convert all the dope fiends in the street into open, honest TC-minded people. In the scene they are generally referred to as TC-freaks or concept freaks. They would not dream of going back themselves, but their proselytism is impressive.

These people get isolated even in the scene itself and in the end they have less than ever before. They do believe in the TC concept but are unable to take part in the network that exists within the community. They suffer because they dropped out, but at the same time they don't stand a chance when coming back. They have to be considered casualties. Among this group is a considerable number of deaths by overdose.

Other facts show that casualties are found especially among those who have unreasonably high expectations of treatment. These people evidently get gradually disappointed up to the point that they decide to drop out.

I am convinced that a lot of programs are not sufficiently aware of the fact that by creating unrealistically high expectations during the process of induction, they contribute to the risk of creating casualties as well. This is why I would like to make a strong plea for providing new members of the TC with real information and to cease from promising the earth to the resident. I am aware of the fact that positive stimulation of clients during the induction phase is important. In addition, research findings also indicate that among the ones who have high expectations of treatment we find casualties as well as very successful graduates. This inevitably leads to the necessity of trying to gather more knowledge about relevant selection criteria, extended them from the ones I mentioned before to some kind of measure to establish a person's ability, or if you will, inability to go through treatment successfully.

I believe that the chance of success is heavily related to the person's ability, as well as to the opportunity he is given, to relate to others in an adequate way. This may give us an explanation why it is so hard to retain certain categories of residents like monopolizing individuals, narcissists, homosexuals, schizoid personalities or even good-looking women. Either they adopt an interpersonal role that puts them outside of the group, or they are forced into a role that deprives them of the possibility to relate to the group through meaningful communication. They will not get valid feedback and self- disclosure is punished by stereotypical reactions. Eventually dropping out is the only alternative and becoming a casualty is an actual risk.

In my opinion, it is easy to disclaim responsibility for these facts by saying that in the end it is the resident himself who decides whether he stays or leaves. It is us who have to improve our selection criteria, correct our attitudes and try to refine our methodology in order to become more competent in dealing with these problems.

Looking at a TC as a system of interpersonal relations gives us a couple of different angles from which we can look at the questions mentioned above.

In the first place, we are forced to determine whether a person can meaningfully participate in such a system. If not he ought not to be admitted, unless we are able to find a workable compromise between maintaining the TC climate on one hand, and putting some more individual attention into a resident on the other hand.

In the second place, we have to be very much on the alert for scapegoating as this phenomenon is more or less the other side of the shield.

Thirdly, we may be able to gain some more insight in the question why certain residents are so difficult to retain. If it is their interpersonal role that creates the problem of dropping out, we might find ways to deal with it, not by trying to change that role (after all it serves a purpose), but by being aware of the possible impact of such an interpersonal role on the group as a whole and consequently by making it a generally recognized phenomenon within the community.

Finally, I have to say that in my experience, the retention rate of a TC is not mainly dependent upon the quality of the staff members, nor upon the number of "good" residents within the group. The critical variable - to a certain extent - is some kind of obecure combination of group members. It is challenging to find out more about this combination in order to enhance our possibilities of predicting a person's chance of success, failure or damage.

Let me finish by saying that, of course, the question of dropping out and of casualties cannot be solely explained from the angle of interpersonal relations. Many more factors underlie this problem. This one, however, deserves more attention that it had until now.

PSYCHIATRIC SEVERITY AND RESPONSE TO TREATMENT IN A THERAPEUTIC COMMUNITY

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Chicago, Illinois

Introduction

Two key questions in drug treatment research today are, first, how much change can be accomplished with people who have different types and severity of problems; and second, which treatment works best for what type of person? The first question acknowledges that we may not be able to accomplish as much with people whose problems are very severe as we can with people whose problems are less severe, irrespective of the treatment provided. The second question suggests that people who have different problems might do better in one form of treatment than in another.

Research on the relationship between psychopathology and treatment has tended to focus on the first issue, that of treatment expectancies. In general, this research has concluded that people with more severe psychological problems show worse outcomes than people with less severe psychological problems, irrespective of the treatment they received. That is, in general we accomplish less with psychologically troubled persons than with less troubled persons. As early as 1972, Pittell and others attempted to identify MMPI variables which could be used to predict success in methadone maintenance. Among their conclusions they stated, "Success in methadone maintenance is more related to the absence of gross psychopathology than to any particular trait or constellation of traits." In 1973, Fisch and others looked specifically at depression and self concept as predictors of success in methadone maintenance. They found that, the more depressed the client, the higher the dropout rate. However, high depressed people who remained in treatment responded positively to methadone maintenance plus counseling, whereas low depressed people did not respond well to counseling.

With respect to the TC, De Leon et al.'s 1973 study found that dropouts from treatment scored significantly worse at intake on several measures of psychopathology compared to residents who remained. Similarly, Zuckerman et al.'s 1975 study found that dropouts from three TCs showed greater psychopathology at admission than those who stayed in treatment.

There is growing interest in the second issue, whether psychologically troubled people do better or worse in one modality than another. A team of researchers at the Philadelphia VA found, initially, that "high severity patients...showed the least improvement and the poorest outcome regardless of which type of treatment they received." In other words, they found no evidence for differential response to treatment. Subsequently they performed additional analyses on the same data and decided that psychiatric severity did predict differential response to treatment. Specifically, they determined that very troubled people did poorly in the TC and did well in methadone maintenance. Their current position is that the longer the psychiatrically severe client remains in the TC, the worse he or she becomes (McLellan et al., 1984).

Another group of researchers at Yale is also working to identify variables which predict differential response to treatment. Consistent with the prior research, they found that troubled people had worse outcomes than less troubled people. However, they found no evidence for differential response to treatment. Troubled people didn't do better or worse in methadone maintenance or TC (Rounsaville et al., 1982).

This study looks at psychological problems over time and the relationship between psychological problems and response to treatment for a sample of substance abusers seeking admission to treatment at Gateway Foundation in Illinois. These data address five questions: First, what is the extent and severity of psychological problems in this group? Second, to what extent is psychological distress at intake a function of drug use or the crises that prompt people to seek treatment? Third, are the worst cases screened out? Fourth, how do symptoms change over time with treatment? And fifth, to what extent does a history of psychological problems predict response to treatment?

This paper challenges the findings of the Philadelphia VA study. Policy recommendations are being made based on the VA data, but these are premature owing to some of the limitation of the Philadelphia VA research and to the existence of contradictory findings described herein.

Keep in mind that high severity means the most severe problems, low severity means minimal or no problems. The actual variables used to define psychological severity vary from study to study, but generally have to do with the number and chronicity of psychological problems experienced.

Method

Eight hundred and eighty-eight substance abusers applied to Gateway for treatment between February 1981 and June 1982. A second cohort of 650 treatment applicants between July 1982 and June 1983 will not be reported on now. Treatment applicants were interviewed by a trained interviewer on the day of their first contact with the program, prior to meeting with a counselor. The pretreatment data are drawn from the structured interview and from the SCL-90, a 90-item self-report symptom checklist. The SCL-90 was readministered one month and three months after admission, and thereafter every three months while the client remained in treatment. In addition, the primary counselor evaluated the client's progress in treatment at the same followup intervals, using a 32-item behavior checklist.

The study sample can be described as long-term users of multiple substances with extensive criminal histories, and with minimal educational, vocational, and other social skills. The sample was 74% male and 64% white. The average age was 24.9 years (+ or -7.0), with a range of 13 to 55 years. Sixty-four percent had never been married, 23% were separated or divorced, and 14% were legally married or living as married. Fifty-six percent had less than a high school education, and 63% had no usual occupation or worked at unskilled or semi-skilled jobs. The clients had been using drugs an average of 8.6 years (+ or -4.8). The vast majority were multiple substance abusers; 91% had used two or more drug classes regularly (at least once a week for a month or more). Thirty-seven percent reported that their primary drug was an opiate, 11% non-opiate depressants, 30% stimulants, 19% marijuana, and the rest other.

Ninety-four percent had engaged in illegal activities in addition to the use of illegal drugs, 89% had been arrested at least once for a non-status offense, and 70% had been convicted on at least one charge. Fifty-four percent were seeking treatment under some form of legal pressure.

Gateway Foundation provides prevention, outpatient and residential drug services in Illinois. This report focuses on the residential program. At the time the report was done, the planned duration of Gateway's residential program was 18 to 24 months. It was a traditional TC with three phases: intensive residential, re-entry, and aftercare.

Results

The SCL-90 taps nine symptom dimensions: somatization, obsessive compulsive, interpersonal sensitivity depression, anxiety, hostility, phobia, paranoia and psychosis.

Somatization refers to a preoccupation with bodily aches and pains. Problems with obsessing or compulsive behavior frequently accompany anxiety or depressive disorders. A person who scores high on interpersonal sensitivity is what might be called "touchy." Phobic anxiety is often more intense and usually more focused than non-phobic anxiety. "Paranoid ideation" on the SCL-90 is comparable to "distrustful." Psychoticism refers to severe thought disorder and delusions. In addition to the nine symptom dimensions, there is a summary score called the Global Severity Index (GSI).

Our first question was, what is the extent and severity of psychological problems in the group?

Figure 1 shows the mean symptom scores for female and male substance abusers, as well as two comparison groups, psychiatric patients and group of normals. For the total Gateway group, the scale scores range from a low of .62 for phobia to a high of 1.40 for depression. The mean global severity index is .95 (.84 for males, 1.25 for females). All of the scores for the Gateway group are significantly above normal.

The profile of the symptom scores is similar for the substance abusers and the psychiatric outpatients. Reported distress is greatest in the area of depression, followed by obsessive-compulsive, and then by interpersonal sensitivity, anxiety, and paranoid ideation.

The females score significantly higher than the males on all of the symptoms, which is a typical finding in psychology.

Table 1 shows other measures of psychological problems obtained from the structured interview. Again, the females show a higher incidence of all problems.

Figure 1

Symptom Scores for Substance Abusers Seeking Treatment and Comparison Groups

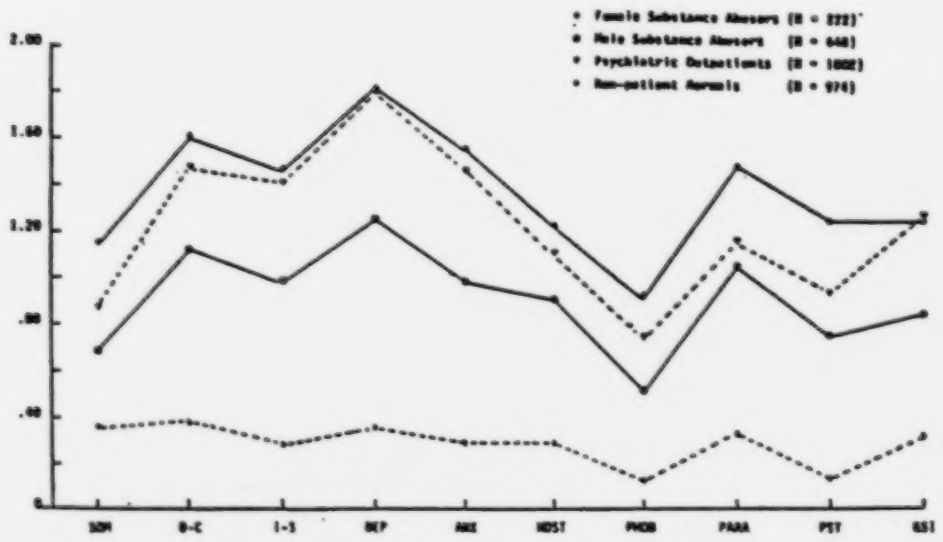
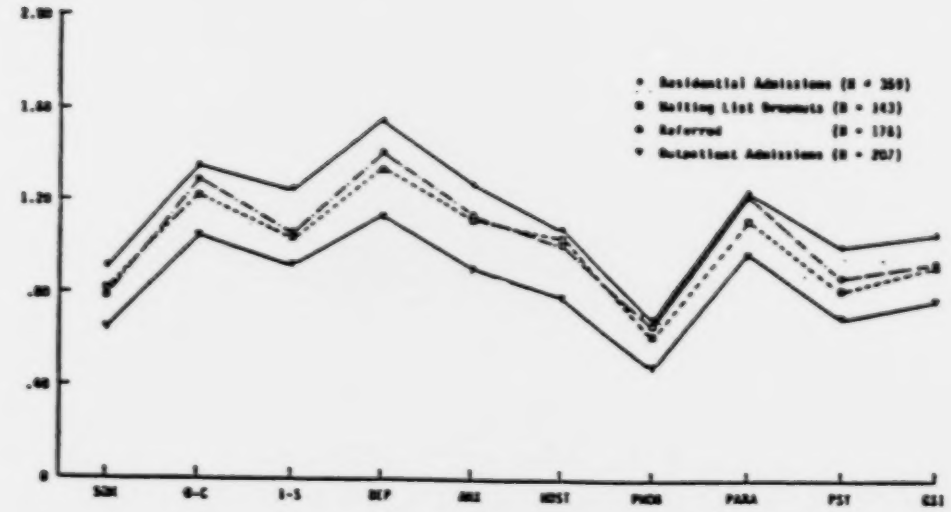


Figure 2

Symptom Scores for Treatment Assignment Groups



The most common problem experienced by this group is confused thinking. The second most common problem is impulse control. Thirty-eight percent have experienced a serious depression. Anxiety disorders are somewhat less common, but 27% have experienced at least one anxiety attack.

It was made clear in the interview that treatment for psychological problems was separate from treatment for drug or alcohol abuse. Seventeen percent had a prior psychiatric hospitalization. This compares to 8% of the Philadelphia VA sample. Another 15% had been treated for psychological problems on an outpatient basis. Again, in the interview we distinguished between a deliberate suicide attempt and accidental overdoses or other drug-related accidents. ç Actual attempts at suicide were made by 28% of the sample. This compares to 17% of the Philadelphia sample. Almost half of the females reported a suicide attempt, and one- fifth of the males.

In summary, the incidence of psychological problems in this group is high, even for a substance abusing population.

Our second question was, to what extent is the psychiatric distress measured at intake a function of the immediate intake situation? In other words, are these abusers really troubled, or do they just look troubled because they're using drugs, coming off of drugs, or because they're in a lot of trouble? The question is an important one for several reasons. We might recommend a different treatment for someone with chronic problems than for someone whose problems are reactive and temporary. In evaluating the effect of treatment, we might want to take into account the fact that some degree of the distress is temporary and that some improvement will occur with time whether or not the person gets treatment. And in comparing the results of different studies, we might want to see whether the study samples are comparable with respect to the distribution of chronic and acute problems. In other words, were the people treated in study A as disturbed as the people treated in study B?

We looked at the relationship between drug use in the month prior to admission; a construct we called "crisis," which represents the amount of trouble the person said he was in with respect to drugs, employment, family, legal, and medical; and the global severity index. We also looked at the contribution of drug use and crisis to the GSI relative to background variables, not including the background çpsychological measures.

Table 2 shows the results of a stepwise regression analysis using the global severity index score as the dependent variable. The model accounts for 37% of the variance in the GSI. Status of intake -- drug use and crisis -- accounts for 13.4% of the variance.

The results indicate, as predicted on the basis of prior research, that intake symptomology is associated with being female, white, and somewhat younger, with less formal education and less job experience. Those who report more distress have a history of multiple, heavy drug use, more often non-opiate. They experienced problems in the family such as illness, unemployment, and violence as well as drug or alcohol use or criminality by family members. While they have been involved in criminal activities, the severity of their involvement is lower than people with lower levels of distress.

In summary: a little more than a third of the psychological distress reported at intake is attributable to the person's immediate situation. About two-thirds appears attributable to demographic, family, and background behaviors. I would conclude that a lot of the distress is long-term, significantly heightened by immediate stresses.

Our third question was, are the worse cases screened out? In other words, does the program systematically refer treatment applicants with psychological problems to other programs or mental health centers? The distinction between a systematic "creaming" of the population and an unsystematic acknowledgment on a case-by-case basis that a given individual is not appropriate for the treatment program is an important one. Gateway sometimes refers people with severe psychological problems to mental health centers. The question here is, does the program try to make its outcomes look better by ç systematically screening out people with poor prognoses? This figure says that the answer is no.

Treatment applicants were divided into three groups: people who were referred elsewhere, people who were assigned to Gateway's outpatient program, and people who were referred to Gateway's residential program. This last group of residential assignees was further divided into waiting list dropouts and those who actually entered a residential facility. Forty-one percent of treatment applicants;ants entered a residential facility, 16% were waiting list dropouts, 20% were referred elsewhere, and 23% were assigned to residential treatment.

Figure 3

Retention Curves for Psychiatric Severity Groups
(Residential Admissions, N=419)

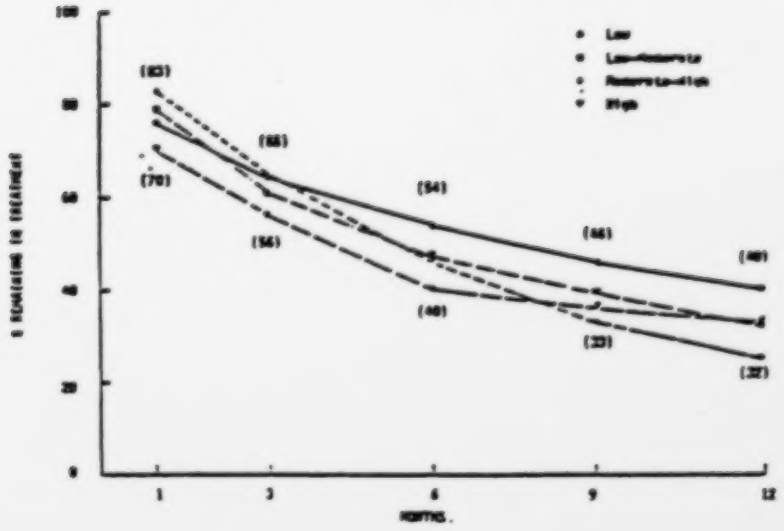


Table 1

Psychological Measures for Substance Abusers Seeking Treatment

Measure	Treatment Applicants		
	Males (N=660)	Females (N=228)	Total (N=888)
Problems Experienced (% yes)			
Became so tense or anxious couldn't breathe	22%	41%	27%
Had trouble with seeing or hearing things that weren't there	23%	40%	28%
Had trouble understanding, concentrating, or remembering	67%	78%	70%
Had trouble controlling temper or violent behavior	57%	64%	58%
Felt so depressed couldn't get out of bed	33%	52%	38%
Number of problems experienced, lifetime: M	2.1	2.6	2.2
SD	1.6	1.6	1.6
Number of problems experienced, past month: M	1.2	1.9	1.3
SD	1.2	1.6	1.4
Treatment for Psychological Problems			
Prior psychiatric treatment: Any inpatient	15%	25%	17%
Outpatient only	13%	19%	15%
None	72%	56%	68%
Prescribed medication for a psychological problem (% yes)	25%	36%	28%
Total time treated (months): M	3.3	6.4	4.1
SD	11.4	17.6	13.3
Suicide			
Attempted	22%	46%	28%
Seriously considered	20%	22%	21%
Never seriously considered	58%	33%	51%
Status at Intake			
Days trouble by psychological problems last month: M	11.5	17.3	13.0
SD	12.8	12.6	13.0
Self-rating, severity of psychological problem (1=not a problem, 4=a serious problem): M	2.3	2.8	2.5
	.9	.9	.9

We compared the four groups on a large number of sociodemographic and background characteristics, including age, sex, race, marital status, drug and alcohol use, educational, vocational, legal, family, medical and psychological history. In brief, the major difference was between the outpatient group and the others. The outpatient group scored better on virtually all the measures -- although better is strictly relative, since their problems were quite severe. Residential clients reported higher levels of severity in all areas, including psychological problems. Among the clients assigned to residential, the severity of problems was exactly the same for waiting list dropouts and those who entered treatment. However, residential admissions perceived their problems as more severe than waiting list dropouts -- that is, their severity ratings were higher; and 45% of residential admissions were probated to treatment, compared to 10% of waiting list dropouts.

In general, in Figure 2, the outpatient group scores better than the other three groups, and there's no difference among the three groups.

Our fourth question was, how do symptoms change over time?

Table 3 shows the symptom scores at intake and six months after admission for a group of residential admissions. As you can see, there was significant improvement on six of the nine symptom dimensions and the global severity index. There were significant improvements in what could be called the neurotic dimensions: obsessive compulsive, depression, and anxiety, as well as in the psychotic dimension. However, there was no change in what could be called psychopathy: at six months, there residents are still touchy, angry, and distrustful. These findings, by the way, are very similar to the pattern of MMPI findings reported by Zuckerman.

To summarize: people are getting better, but slowly. The symptomology is still relatively high. And there has been no change in those traits often felt to be uniquely characteristic of addicts.

Our last question was, to what extent does a history of psychological problems predict response to treatment? In these analyses, we used two measures of response to treatment. One was time in program. Prior research suggests that time in program is the single best predictor of posttreatment outcomes for TC clients (e.g., Holland, 1983). The longer a person remains in treatment, the greater the probability that he or she will show positive outcomes on a variety of measures. In this study, we're using time in program as a proxy for posttreatment success. Our second measure of response to treatment is the counselor's evaluation of the resident's performance during treatment.

This table shows the intake SCL-90 scale scores for 6 time in çprogram groups, according to when residents dropped out of treatment. The TIP groups are not different at intake except on phobic anxiety. As you can see, it's the low 6-to-9 month group's score that's causing the effect. In general, the 3-to-6 month group scores the highest and the 6-to-9 month group scores the lowest on all scales.

We also looked at the relationship between the intake interview psychological measures and time in program. Three of these measures were correlated with TIP at a statistically significant level, but the correlations were low: -.08 and -.10.

We created a composite measure of psychological severity similar to the one used by the Philadelphia researchers, which reflects number and chronicity of psychological problems experienced. The correlation between this measure of severity and TIP is -.08, which is statistically significant but not meaningful clinically.

This figure shows percent remaining in residential treatment after 1, 3, 6, 9 and 12 months after admission for four psychiatric severity groups.

At the end of six months, 40% of the high severity clients are still in treatment compared to 54% of the low severity group. That 14% difference is the largest at any point along the curve. By the end of 12 months, however, the high severity group is doing as well as one of the mid-range groups and better than the other mid-range groups with respect to retention.

What is clinically significant about these data is the high retention rate for all four groups. At the end of 12 months, 32% of the high severity and 40% of the low severity group are still in treatment. These are excellent rates for a TC.

The counselor ratings tell essentially the same story. Counselors rate the high-severity clients' progress as less satisfactory than the other groups. So there is a difference is their performance. But the actual difference in the ratings is clinically insignificant.

Table 2

Client Predictors of Psychological Status at Intake*

Predictor	r	ΔR^2
Demographic		
Sex (0=male, 1=female)	.28	.074
Race (0=white, 1=nonwhite)	-.17	.030
Age at admission	-.05	.001
Family		
Problems in the family while growing up (0-9)	.29	.056
Deviance in the family while growing up (0-3)	.08	.002
Background		
Drug use		
Number-frequency index	.25	.037
Frequency of use, depressants (0=none, 8=4+ times/day)	.23	.003
Duration of use, inhalents	.10	.007
Problems experienced owing to drug use (0=no, 1=yes)	.14	.008
Prior treatment for drug abuse (0=no, 1=yes)	.04	.005
Criminality		
Most serious conviction (0=none, 6=crime against persons)	-.15	.008
Total months spent in jail	-.14	.003
Employment and education		
Months worked at longest full-time job	-.07	.003
Years of education	-.09	.003
Intake		
Severity ratings (1=not a problem, 4=a serious problem)		
Severity of drug problem	.28	.020
Severity of employment problem	.25	.015
Severity of family problem	.29	.011
Severity of medical problem	.40	.081
Days used drugs past month	.20	.007
% of Variance (R^2)		.374
Adjusted R^2		.356
Number	713	

* Dependent variable is the Global Severity Index measured at intake. A higher score on the GSI indicates greater psychological severity.

Summary

1) The incidence of psychological problems is high in this sample of substance abusers, including suicide attempts, prior psychiatric hospitalizations, and serious problems with impulse control, depression, and anxiety.

2) While a significant proportion of intake symptomology appears to be a reaction to the problems which prompted these abusers to seek treatment, many also have histories of chronic psychological problems.

3) The most seriously disturbed clients are not systematically turned away from the program, although applicants can be and are assessed as inappropriate for the program owing to psychological problems and referred to psychiatric hospitals on a case-by-case basis. From the applicant population, clients assigned to the residential program tend to have the most serious problems in all areas, while clients assigned to the outpatient program tend to have the least severe problems.

4) After six months in residential treatment, significant improvement was seen in six of the nine symptom dimensions and the global severity index. There was no change in the three measures of psychopathy considered by some to be the defining characteristics of addicts -- difficulty with interpersonal relationships, impulse control, and distrust.

5) Neither lifetime measures of psychological problems nor intake measures of symptomology were clinically useful in predicting response to treatment. While treatment outcomes were somewhat less positive for high severity clients, in line with previous research, their retention in Gateway was higher than the average client in the average TC and their rate of improvement was steady in the estimation of counselors. There was no evidence that these clients got worse over time.

Discussion

In the introduction it was stated that the recommendations of the Philadelphia VA group are premature owing to several factors. First, their study involved only one TC and one methadone maintenance program. Independent replication in other programs is required before results can be generalized to the modality as a whole. Second, the TC in the Philadelphia study had a planned duration of 60 days. Mean length of stay was 51 days. Many people would say, that is not a TC. Many people also would not expect serious, long-term problems to disappear in a few weeks. Third, the high severity samples included 28 people in the TC and 30 people in methadone maintenance. In my opinion, policy recommendations should not be based on such small samples.

But the major problem with the study is: there was no effect. The regression analyses which purportedly show that high severity clients get worse in the TC are described by the researchers as "idealized" functions. That is to say, they don't exist. The purported effect is a statistical sleight-of-hand.

A critical problem with this area of research is the lack of a common definition for "psychiatrically severe." If the Philadelphia VA researchers have in mind the Vietnam vet who carries a dagger in his boot and tries to dig foxholes in the living room, I agree that the TC does not do well with that person. I would also hope that some other program might be able to help him.

But a significant proportion of the sample in this study could also reasonably be diagnoses "psychiatrically severe," yet their prognosis with TC treatment is very good. The premature use of such vague diagnostic labels to assign people to treatments will result in a large number of false positives, and quite probably, to the provision of expensive hospital-based psychiatric care to these false positives when less expensive community-based care would be equally effective, perhaps more so.

A second critical problem with this area of research is the application of a single treatment label, "TC," to programs that differ enormously in the strength of treatment provided. It is irresponsible to suggest that the outcomes of a 60-day TC are representative of the outcomes of all TC's. One of the goals of this research should be to determine how strong the treatment needs to be in order to impact the problem to be treated. Presumably, stronger treatments are required to impact more severe problems. Thus, if a relatively weak, 60-day treatment fails to alleviate the problem, it does not follow that a stronger form of the treatment would also fail.

Conversely, if a program is successful in treating psychiatrically severe clients, it's worth looking at what the program does in an attempt to identify effective approaches and procedures. It's my impression that the "confrontive" aspect of the TC obscures some of its other, equally important aspects, such as the constant

Table 3

Symptom Scores at Intake and 6-Month Followup for Residents (N=147)

Symptom Dimension	Intake	6-Month Followup	t
Somatization	.80	.66	1.98*
Obsessive-compulsive	1.26	.93	4.77**
Interpersonal sensitivity	1.15	1.08	1.06
Depression	1.39	.98	6.14**
Anxiety	1.11	.70	5.74**
Hostility	.95	.88	.88
Phobic anxiety	.57	.40	2.95**
Paranoid ideation	1.16	1.10	.73
Psychoticism	.90	.66	3.84**
Global severity index	.95	.73	4.31**

* $p < .05$, two-tailed test

** $p < .01$, two-tailed test

Table 4

Intake Symptom Scores for Residents by Time in Program

Symptom Dimension	Months in Program						F
	< 1 (N=100)	1 - < 3 (N=64)	3 - < 6 (N=54)	6 - < 9 (N=33)	9 - < 12 (N=24)	12+ (N=144)	(5,413)
Somatization	.88	.89	1.08	.65	.74	.83	1.39
Obsessive-Compulsive	1.33	1.28	1.53	1.07	1.20	1.30	1.22
Interpersonal Sensitivity	1.18	1.30	1.43	.84	1.12	1.19	1.81
Depression	1.51	1.51	1.70	1.19	1.34	1.50	1.47
Anxiety	1.29	1.18	1.45	.85	1.09	1.19	1.97
Hostility	1.16	1.04	1.39	.95	.93	.93	2.10
Phobic Anxiety	.65	.64	.88	.31	.69	.60	2.59*
Paranoid Ideation	1.20	1.26	1.52	.96	1.22	1.18	1.67
Psychoticism	.96	1.01	1.18	.72	.95	.93	1.43
Global Severity Index	1.03	1.02	1.24	.79	.94	.99	1.94

* $p < .05$.

surveillance and the labeling and expressing of feelings that make it a very safe and effective form of treatment for distressed people.

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PSYCHIATRIC DISORDER IN THERAPEUTIC COMMUNITY ADMISSIONS

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The pervasive use of drugs in the general population has stressed the need for clarification of psychological factors in the treatment of individuals seeking mental health or drug treatment services. There is an extensive literature documenting the presence of psychopathological signs among drug abusers entering therapeutic communities (De Leon, 1976; De Leon et al, 1973; Zuckerman et al, 1975); and studies have also reported significant improvement in the psychological profiles of drug abusers in treatment and at follow up (De Leon, 1984; De Leon and Jainchill, 1981-82). Nonetheless, the relationship between addiction and psychopathology is still not well understood. Drug abuse may be antecedent, consequent to, or correlated with psychopathology.

A major question remains concerning the actual prevalence of psychiatric sickness and the relevance of psychiatric diagnosis in the treatment of substance abusers. The present paper reports findings that bear upon this question. Psychiatric diagnoses (DSM-III) were obtained with the Diagnostic Interview Schedule (DIS) on a sample of 40 clients entering Phoenix House residential treatment between January, 1985 and May, 1985.

Method

The DIS is the most recent of a series of structured interviews, originally developed for use in a national survey to assess prevalence and incidence of psychiatric disturbance in the general population. The DIS can be administered by trained lay interviewers, as well as by psychiatrists. The interview is read verbatim to the respondent, and covers 43 DSM-III categories. The presence of symptoms are recorded, but severity is differentiated (i.e., subclinical occurrence) as are non psychiatric attribution(s) of the condition. Lifetime and most recent occurrence are obtained for all symptoms.

The DIS was administered by a research psychologist immediately after an individual had been admitted to residential treatment, but prior to transfer to a residential facility. The length of an interview varied directly with the extent of reported problems, but averaged one hour across the sample.

The Sample. The sample of 40 admissions was 65% male, 73% black, 50% were 21-26 years of age, and 45% reported cocaine as their primary drug. (See table 1).

The sample, randomly selected, differed from the Phoenix House residential population in that a greater proportion of female admissions was interviewed and there were few clients under 19 years of age (since the DIS is recommended for individuals 18 years or older).

Phoenix House is the nation's largest treatment system for substance abusers utilizing drug free approaches in both residential therapeutic communities and non residential modalities. Complete descriptions of Phoenix House are contained in other writings (e.g., De Leon and Rosenthal, 1979, 1985).

Results

Table 1 shows that of the 40 admissions, 37 (92.5%) obtained at least one diagnosis, while 3 (7.5%) received no diagnosis. Thirteen (32.5%) obtained one diagnosis only. Nine (22.5%) yielded a substance diagnosis (Drug Dx) only (12.5% Abuse, 7.5% Drug Dependence and 2.5% Drug Dependence + Drug Abuse); and four admissions (10.0%) obtained a non Drug Dx only. The remaining 24 admissions (60.0%) obtained a Drug Dx plus at least one other non drug diagnosis; of these 11 (27.5%) had 2 diagnoses and 13 (32.5%) obtained more than two diagnoses. Thus, virtually all received a diagnosis and most dual or multiple diagnoses.

In DSM-III drug diagnoses exclude alcohol. A Diagnosis of Dependence requires physical tolerance changes in addition to the behavioral criteria for a diagnosis of Drug Abuse. In this paper, the terms substance and drug are used interchangeably.

Table 1

Diagnostic Interview Survey

Sample Characteristics of 40 Admissions
to Phoenix House, NY (1985)

	N	%
Totals:	40	100.0
Sex		
Males	26	65.0
Females	14	35.0
Ethnicity		
Black	29	72.5
Hispanic	7	17.5
White	3	7.5
Other	1	2.5
Age		
18 years	4	10.0
19-20 years	4	10.0
21-26 years	20	50.0
27+ years	12	30.0
Primary Drug		
Heroin	9	22.5
Cocaine	18	45.0
Marijuana	7	17.5
PCP	2	5.0
Alcohol	3	7.5
Pills	1	2.5

Recency of psychiatric disorder was assessed since time of symptom occurrence is obtained on the DIS. Among the admissions with a diagnosis (N=37) all were symptomatic in the last year, and all but one were symptomatic in the month prior to entering treatment. For those who had a psychiatric diagnosis other than or it addition to chemical abuse, 64% were initially symptomatic in the year before being admitted to Phoenix House. Over 20% had a psychiatric disorder in both the past (more than 1 year before treatment) and present, although the diagnosis may have changed.

Table 1 shows the prevalence of all diagnoses for the sample. Among the chemical diagnoses the order of occurrence is Drug Abuse (77.5%), Drug Dependence (47.5%), Alcohol Abuse (22.5%) and Alcohol Dependence (17.5%). Among the nonchemical diagnoses, the order of occurrence is Phobias (37.5%: Social Phobia, Simple Phobia, Agoraphobia with or without Panic Attacks), Antisocial Personality (20.0%), Major Depressive Disorder (12.5%, which includes 5% categorized as Dysthymic), Pathological Gambling (12.5%) and Obsessive Compulsive (10.0%). Percentages for other diagnoses are small (e.g., Mania, 2.5%; Grief Reaction, 5.0%; Schizophrenia, 5.0%; atypical Bipolar Disorder, 5.0%).

Although sample size was too small for statistical testing, differences were observed, mainly by sex. Females more often obtained a diagnosis in addition to that of substance abuse or substance dependence. While males more often received a diagnosis of Drug Dependence, a greater proportion of females were diagnosed with Alcohol Abuse or Alcohol Dependence. Males more often obtained a diagnosis of Antisocial Personality and Agoraphobia, while females were more frequently diagnosed with Simple Phobia. Notably, all but one of the affective and schizophrenia diagnoses were attributed to females. Finally, more cocaine abusers received a Drug Abuse diagnosis only, with no accompanying diagnosis.

Overall, relatively few 1985 admissions enter treatment with a Drug Abuse/Dependence diagnosis only. Most reveal psychiatric disorder in addition to substance abuse or dependence. The most frequent

accompanying diagnoses are Phobia, Antisocial Personality, with few cases of psychosis or severe affective disorder. Although symptoms usually appear proximal to the time of entry into drug treatment, a considerable minority have a past and/or continuing history of disorder.

Discussion

The diagnostic findings are consistent with those obtained in a number of other psychological studies. These report the presence of psychopathological signs among drug abusers who seek treatment although there is little evidence of psychosis or severe psychiatric disorder. Substance abuse is viewed as a prominent element in a psychological profile that contains features from both psychiatric and criminal populations. For example, the antisocial characteristics and çpoor self-concept of delinquent and repeat offenders are present, along with the dysphoria and confused thinking of emotionally unstable or psychiatric populations. Thus, the drug abusers who come to treatment do not appear to be "sick" as do patients in mental hospitals, nor are they characteristic hardcore criminal types, but they do reveal a considerable degree of psychological disability (De Leon, 1984; De Leon & Jainchill, 1981-82).

That psychosis is relatively rare is consistent with research findings and clinical impression. In part, however, it also reflects admission practices in drug abuse treatment centers, which exclude clients who reveal evidence of frank psychiatric disorder on interview. Furthermore, psychiatric referrals to drug treatment centers have, until recently, been limited. Notwithstanding these sources of bias, the prevalence of dual and multiple diagnoses indicate a wide range of psychiatric symptoms requiring considerable attention.

The results on time of occurrence contain implications for differential diagnoses. Most admissions report that their symptoms first appear proximal to entry into treatment. This finding accords with considerable research and hypotheses emphasizing the distinction between longstanding and transient psychiatric disorder associated with circumstantial stress. The majority of substance abusers enter treatment under negative external stress (e.g., legal, health, social, economic) that is highly correlated with symptoms, usually anxiety and depression. These dramatically reduce within a relatively short period of time after admission to treatment (e.g., De Leon, 1984; Rounsaville et al, 1985). Differential diagnosis, therefore, should clarify this distinction between transient and more enduring psychiatric disorder.

Notwithstanding the above, almost a quarter of admissions had longer histories of psychiatric problems. Further illumination of these subgroup differences with respect to diagnosis, retention in treatment and outcomes, await results from larger samples of research currently in progress.

Most admissions view their substance abuse to be their main problem; only a few actually received a substance abuse diagnosis without some other psychiatric diagnosis. This finding confirms a common clinical impression that substance abusers report many symptoms, often as complaints, but they do not recognize or acknowledge the severity of other psychiatric problems. among new admissions, for example, the most usual reason given for seeking treatment is fatigue with the drug lifestyle; only a third seek help for psychological reasons (De Leon, 1976, 1980). However, treatment strategies (such as those emphasized in therapeutic communities), must focus on confronting denial and raising client awareness of the need to address other problems.

Contrary to expectations was the low frequency of Antisocial Disorder. Admissions to the major drug treatment modalities have significant histories of criminal involvement (e.g. 60-80% have been arrested, 50-60% have a legal status at entry, 30% are actually legally referred to treatment from the criminal justice system (e.g., CODAP, 1981). Within this context of criminal involvement the relatively low frequency of a diagnosis of Antisocial Personality appears discordant. This again underscores the importance of further differentiation of apparently similar subgroups of abusers. Thera-peutic community research, for example, has identified at least two antisocial types. In one, drug abuse appears as the important element which initiates, influences or maintains antisocial activity. For a smaller group drug abuse is but one element in a longstanding picture that is fundamentally more character disordered. This distinction, termed Primary and Acquired Antisocial Personality, has obvious implications for diagnosis and treatment (Wexler and De Leon, 1981).

Table 2

Psychiatric Diagnoses (DSM-III)* on the Diagnostic Interview Survey for 40 Admissions (1985) to Phoenix House, NY

	N	%
Totals:		
Any Dx	37	92.5
Substance Dx Only (Abuse &/or Depend.)	9	22.5
Psychiaatric Dx Only (Nonsubstance)	4	10.0
Substance Dx Plus Other Dx**	24	60.0

Diagnosis	%
Substance Abuse (DSM-III)	77.5
Substance Dependence (DSM-II)	47.5
Alcohol Abuse	22.5
Alcohol Dependence	17.5
All Phobias (Social, Simple Agoraphobia with or without Panic Attacks)	37.5
Antisocial Personality	20.0
Pathological Gambling	12.5
Obsessive Compulsive Disorder	10.0
Major Depressive Disorder	7.5
Dysthymic Disorder	5.0
Grief Reaction	5.0
Atypical Dipolar Disorder	5.0
Schizophrenia	5.0
Mania	2.5
Psychosexual Dysfunction	2.5

* Tobacco Diagnoses are excluded from all analyses. The terms "substance" and "drug" are used interchangeably.
** Substance Abuse and/or Substance Dependence plus other diagnoses (dual or multiple). Diagnoses of Alcohol Abuse and/or Dependence (N=2) considered as "other" diagnoses for this analysis.

That Depressive Disorders occurred in less than 15% of the cohort is also discordant with clinical impression and considerable research showing a relationship between depression and addiction. Again, resolution of this discrepancy may lie in careful differential diagnosis which searches out the distinction between recent (within a year) and long standing symptomatology.

Similarly, the relatively high percentage of Phobic Disorders remains to be understood. Examination indicated that in most cases Phobic symptoms were of more recent onset. However, the sample was too small for statistical analysis of recency by type of disorder. It is possible, also, that the nature of the questions in the DIS probed "positive" phobic diagnosis. This question must be addressed in related studies.

Finally, consistent with earlier studies that report women more psychologically disturbed on admission to treatment, females more often have non-substance diagnoses while males are more frequently diagnosed as Drug Dependent. A hypothesis to be explored in subsequent research is that the grater psychological upset of females may precipitate their admission to treatment before their drug abuse becomes as severe as their male counterparts.

Although obtained in a drug treatment program, present findings ç emphasize the need for parallel studies in mental health centers which focus on the detection of substance abuse problems among psychiatric patients. An understanding of drug use in the initiation or exacerbation of psychiatric conditions is essential to proper diagnoses, management and treatment of patients in mental health or hospital settings.

With regard to treatment in particular, research has convincingly documented the effectiveness of the therapeutic community approach in proving both social and psychological adjustment among clients whose primary presenting problem is drug abuse. Post treatment improvement in psychological status has been highly correlated with positive behavioral adjustment with respect to drug use and criminality (e.g., De Leon, 1974; 1984; De Leon and Jainchill, 1981-82; De Leon et al., 1973; Simpson and Sells, 1982). These findings obtained on drug abusing populations with psychiatric symptoms have implications for employing similar treatment strategies for psychiatric populations with substance abuse problems.

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DIAGNOSIS & TREATMENT OF THE DUAL DIAGNOSIS CLIENT

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The traditional gap between mental health and chemical dependency which has spawned two types of service provision is closing. Practitioners in each of the two fields are finding that there is considerable crossover and overlap of chemical dependency and psychological problems. Patients with significant psychopathology are either appearing or else being recognized with increasing frequency in TCs whose treatment focus is chemical dependency. The reasons for this are many and complex, but certainly the increased prevalence of substance abuse in the general population, movement of mental health professionals into the chemical dependency field, and inadequate public services for the dual diagnosis client are contribute to this phenomenon.

The TC treating substance abusers must begin to look more closely at the shifting population of its clientele. Early forms of the substance abuse TC (e.g. Synanon) were composed of a far more homogeneous resident population, primarily heroin addicts with criminal history. The highly confrontive Synanon "games" and other elements of the Synanon TC were appropriate treatment methods for this "hardened" population, which the mental health community had labeled "untreatable." Diagnosis during this era of the TC was made by drug type used; you had an alcohol problem, a "drug" problem or a "psychiatric" problem.

Currently most modern TC's treating substance abusers recognize the presence of a "dual diagnosis" subpopulation within their larger "single diagnosis" chemically dependent population. It is generally believed that the "dual diagnosis" subpopulation is a small percentage and in many cases "dual diagnosis" in the TC is a term for someone with dramatically overt psychopathology. It is our contention that this dual diagnosis subpopulation is actually quite substantial. In order to effectively treat this increased segment of the TC population it is essential to consider both elements of the dual diagnosis so there is awareness about how both psychological problems and substance dependency contribute to the patients difficulties. To treat only the substance abuse problem or only the psychological problem is incomplete treatment which will result in diminished, and sometimes failed treatment. It is our observation that most TC's assume that the great majority of their residents are "single diagnosis" substance abusers; psychological issues are not systematically dealt with in the treatment program. Without adequate awareness and treatment accommo dation to the character and symptomatic problems of the substance abuser simple cessation of substance abuse behaviors will lead to recidivism or substitution of other substances to abuse.

Given our premise that the current composition of the TC is far more heterogeneous and has far higher presence of the dual diagnosis patient, diagnosis and treatment become more challenging. In the examples of diagnosis and treatment which follow it will be our contention that although substance abuse and psychological issues are inextricably interwoven in the real person, it is clinically useful to separate the two in order to more accurately assess the features of each. In addition, diagnostic separation and consideration of the substance abuse and psychological elements of the clients' problem lead to more accurate and "three dimensional" understanding of the relationship between the two, i.e. what aspects of the patient's problem is caused by substance abuse and what aspects of the patient's substance abuse is symptomatic of his or her psychological problems. Clearly, this set of assumptions about how to approach the "whole" patient (rather than simply a small portion of his problems) leads to an increased sophistication and effectiveness in actual treatment.

DIAGNOSTIC ISSUES

In order to best accomplish this goal of more sophisticated diagnostic consideration of the dual diagnosis patient an admission assessment prior to acceptance into the program is essential. Our experience at Walden House has led us to specify three levels of admission assessment: 1) clear exclusion, based on some patient problems which would make use of the program impossible; 2) a "trial acceptance" group which has demonstrable issues which are proble matic for the milieu, but with complete diagnostic assessment and "specially tailored" treatment plans may effectively use the program; and 3) a "clear acceptance" which requires consideration of how their character and pathology or personality will interact with the milieu. These three categories will be discussed with examples.

CLEAR EXCLUSION

At Walden House we exclude five basic kinds of presenting problem: First, is the patient with organic problems serious enough to prevent effective communication or the functioning in the daily aspect of the TC. In this category there are the seriously hyperactive or attention deficit disordered client, the mentally deficient or seriously retarded individual, the organ-ically delusional or affectively disturbed patient, and the large group of brain lesioned patients who have a variety of neuropsychological deficits serious enough to warrant exclusion.

Second is the psychotic patient, which frequently includes patients who are not overtly psychotic on admission screening but are clearly determined to be after assessment. Third are patients with demonstrable suicidal or homicidal ideation. This kind of patient with demonstrable suicidal or homicidal ideation and history may be situationally intensified by the circumstances often surrounding admission (loss, confrontation by family members, criminal prosecution) and may not actually have a problem which will continue beyond admission and stabilization within the milieu. As a general guideline patients with histories of "hysterical" attention-getting suicidal gestures in a context of interpersonal disappointment or frustration will often become difficult management problems in the TC. Residents are quick to sense the manipulative nature of this behavior and may be intolerant or punitive towards it. The presence of prior suicidal behavior or even current passive suicidal ideation should not be automatic exclusion criteria. It is not uncommon in our experience to see patients who present passive suicidal wishes but are clear about not having active intentionality.

Finally, there is a group of "management problem" patients which may include both administrative and clinical problems. Patients with histories of arson are not accepted at Walden House for obvious reasons. Patients with histories of child molestation are excluded both because the legal liability inherent in exposing these patients to minors, but also because of the considerable stigma attached to the child molester by residents who may be aggressively intolerant of this problem.

TRIAL ACCEPTANCE

The second category is necessarily broader and somewhat harder to define. It includes, as does the exclusion category, patients who are at risk to be harmed by the treatment milieu, as well as those who represent management difficulties. From a diagnostic standpoint, these individuals may be those with phobias which impinge on participation in the community, those of borderline intelligence, those with significant neurologic impairment that may be hard to manage or treat and those with affective disorders which are sub- acute, among others. Aside from these individuals, who present relatively clear symptoms, are a number of others who may be somewhat harder to identify. They may or may not have histories which include treatment for psychiatric difficulties. They are nevertheless distinct and their distinctiveness may be hinted at very easily in their contact with the TC. They may be described by intake workers, for instance, as evoking "different feelings" in the interview than the "average" prospective TC candidate. This group is hard to describe succintly. However, for the purposes of patient management, their most important trait is a tendency toward situational, stress- related decompensation, triggered by any of the following:

(1) severe self-blame;

(2) low tolerance for intense affect;

(3) poor ability to objectify authority demands; and/or

(4) confusion between self/other boundaries under stress.

CLEAR ACCEPTANCE

Virtually all TC's, of course, accept their clients on a trial basis and subject them to an orientation period in which they must "earn their way" into the community. The term "clear acceptance," therefore may seem a misnomer. Nevertheless, a large group of individuals who petition for TC membership tend to be seen by the staff, both by history and presentation, as good TC candidates. The question of eventual treatment success is typically conceived of by the staff almost exclusively in terms of the client's motivation and willingness to change. While this is an appropriate conerstone of TC treatment, a large number of the patients in this "majority" group suffer from conditions which are psychologically debilitating, attention to which may be vital to the patient's success. These conditions run the gamut from learning disorders through phobias or anxiety-related orders which may not emerge in the TC environment (i.e., agoraphobia or sexual dysfunctions) to sub-clinical, chronic (sometimes called "characterological") depression. The primary danger with this group is that the problem may be either ignored completely or defined by staff as simple by-

products of the presenting substance abuse problem. Lack of clinical work on these problems may eventually spell disaster for the patient's recovery.

It is our strong conviction that focusing assessment at the ear liest phases of treatment is the wisest use of typically limited resources. A three level "funnel" system is optimal. In this type of system, each prospective client is initially assessed by a combination of structured interview and an objective psychological inventory; the object being to identify psychopathological symptoms, past or present.

Both interview and inventory can administered by paraprofessionals with appropriate training and review by a professional. A good model of a structured interview designed for the addicted populations is the Addiction Severity Index (McLellan, Luborsky, O'Brien, et al, 1980).

Standard "gross pathology" psychological inventories include the Beck Depression Inventory and the Hopkins Symptoms Checklist, also called the SCL-90 (Derogatis, Lipman and Covi, 1973).

In the second level of the assessment system, those individuals (at this point, either prospective or accepted clients) whose responses indicate histories of pathology may be administered more involved psychological inventories (i.e. the MMPI or the MCMI) and be interviewed in more depth by a trained psychodiagnostician.

The third level of assessment is reserved for individuals who present the most complex diagnostic questions. This is the level of the traditional in depth evaluation by a psychologist or psychiatrist and may include full-scale personality and/or neuropsychological testing.

TREATMENT

Once a dual diagnosis patient has been accepted into the TC, the challenge becomes one of determing how many of the patient's clinical problems may be reasonably worked with during his or her stay in the TC and which are more approriately dealt with in aftercare.

The next question becomes how much to modify or augment the basic program to meet the patient's clinical needs. The basic tools available for this may be remembered by the mnemonic phrase "To Gloss Over May Mean a Terrible Outcome," deciphered as follows: To (meaning Therapy or individual psycho-therapy); Gloss (inclusion in special groups); May (medication); Mean (modification of the milieu including modified assignments, specialized exercise programs etc.) a Terrible (training, particularly for learning disabilities or other neurologically-related conditions); Outcome (outpatient or aftercare often insufficiently emphasized both by staff and resident, as the individual reaches the later stages of the TC program.)

Although it is not possible, within the scope of this paper, to be comprehensive, an example dealing with a reasonably common clinical syndrome may help illuminate this concept.

One type of patient which seems to be seen with regularity in the TC is the individual suffering from an attention deficit: This phrase is the latest in a long series, including "minimal brain dysfunction", "hyperkinesis" hyperactivity" and specific learning disability", used to label an often hard-to-define cluster of symptoms. Fundamentally these symptoms revolve around pervasive (through typically fluctuating) difficulties in focusing attention, which usually manifest in problems with impulsivity, disorders of memory, thinking and/or speech. In children this problem often includes (and normally comes to the attention of adults because of) difficulties with behavioral hyperactivity. Until recently, it was widely believed that most such children "grew out" of this problem. However, it is now understood that although behavioral hyperkinesis in most cases does subside with age, attentional problems persist into adulthood in a relatively large subgroup. This subgroup is now understood to be at very high risk for both chemical dependency and personality disorder; in particular the antisocial personality disorder. Interestingly, this group often migrates toward amphetamine, one of the pharmaceutical treatments of choice, and often reports a paradoxical calming effect for moderate doses.

Applying the mnemomic phrase "To Gloss Over May Mean a Terrible Outcome," we find: (1) "To" (therapy) - once the condition can be identified, the individual with appropriate intelligence and abstracting skills can often make good use of individual therapy. Lifelong self-esteem deficits often cluster around school failure, parental frustration and a chronic sense of "not being quite right." (2) "Gloss" (special groups) - when a sufficiently large group of such individuals exist, a special on-going group can help residents cope with the stigma of having a brain disorder and provide valuable peer support. (3) "May" (medication) - Medical treatment of choice are several of the more activating anti-depressant drugs, magnesium pemaline (a slow acting amphetamine, therefore perceived to be less attractive for abuse) and ritalin. Although ritalin is obviously less desirable for this type of patient because of its abuse potential, some individuals with severe

cases may not respond adequately to the other medications. Individuals, especially adolescents, with marked problems with impulsivity may benefit from low doses of an anti-psychotic drug such as mellaril. One encouraging note in our experience has been the observation that although some individuals appear to need medication for indefinite periods and deteriorate markedly when medications are withdrawn, others seem to make and maintain great gains with drug trials of several months duration. Use of medications such as these obviously requires impeccable in-house security and the ability to work closely with a physician highly knowledgeable both of this conditions and residential drug treatment. (4) "Mean" (modification of milieu) - Some attention - deficit patients may experience deterioration of functioning in specific circumstances. Some, for instance, become especially irritable and even prone to rages with fatigue in the late afternoon. Others may have a very low tolerance for performing work that requires even moderate concentration in crowded or noisy conditions. To the extent possible, these needs should be honored without turning the patient into a privileged special case. There is also some suggestion that moderate, regular exercise may help these individuals feel less "fidgety" and therefore, may be able to help them concentrate. (5) "a Terrible" (training) - A variety of approaches to developing auditory and visual memory may be helpful. With treatment, these individuals are often more amenable to educational remediation, since they may be able to learn academic material more successfully than was ever previously possible. (6) "Outcome" (outpatient, or aftercare) - focus on attention - deficit related problems will often be vital to treatment success in these cases. Abuse potential of medications obviously becomes crucial once the patient leaves the structure of the TC. Continuation of individual therapy and peer support groups may be very important, since (as with chemical dependency) the temptation may be powerful to hope the difficulty will "go away", rather than remain as the chronic lifestyle problem.

CONCLUSION

The modern TC is clearly in a state of flux. Pressures from the mental health system to deal with chemical dependency as a psychiatric illness has forced (and will continue to do so) the TC to become more sophisticated in diagnosis and treatment of the dual diagnosis patient. It is our hope that the preceding thoughts on diagnosis and treatment of the dual diagnosis client will increase the sophistication and effectiveness of the TC in dealing with the population.

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THE USE OF PSYCHIATRIC MEDICATIONS IN A DRUG FREE TC

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The purpose of the present paper is to address the issue of using medication in a drug free therapeutic community, when it is, appropriate, and how do we differentiate between drug use/abuse and medically supervised chemo-therapy for people whose drug addiction is secondary to their fundamental problem of psychiatric or psychological disorders.

It is common knowledge that the therapeutic community approach was made popular by British psychiatrist, Maxwell Jones to treat schizophrenics, by recognizing that to some degree they are able to help each other when they are protected against competition and manipulation.

We also know, however, that the traditional aggression-encounter and confrontative style of the ex-addict run therapeutic community is inappropriate for people who are more fragile or suffering from a psychotic disorder. They cannot cope with a probing - confrontative style which would be undermining and destructive.

Odyssey House began in New York City in 1966 and now has programs in five states in America, two in Australia and two in New Zealand. The basic philosophy on the use of medication is common to all the Odyssey House programs. However, the author of the present paper is the Director of the Victoria, Australia program and will primarily focus on the Australian/New Zealand experience which represents approximately 300 residential treatment beds and seven years of operation since 1977.

The founder of the Odyssey program, lawyer/psychiatrist, Dr. Judianne Densen-Gerber was able to distinguish the Odyssey method from other drug rehabilitation programs by describing it as a "Psychiatrically oriented therapeutic community for the rehabilitation of drug addicts". The two major ingredients that qualify the term "psychiatrically oriented" are:

1. The staffing structure includes both the university trained health professional, and the ex-addict person on a 50/50 basis.

2. There is an extramural quality control and psychiatric supervision of each case on a regular basis.

Every one is given a psychiatric and psychological assessment during the first 2-6 weeks of the motivational stage of the program and a long and short term treatment plan is devised by level I of the treatment phase. This will be described in greater detail later in the paper.

We are not a psychiatric hospital, we believe strongly in accountability and everyone is held responsible for their actions at all times. Consequential thinking is considered a major part of treatment and a healthy sense of guilt for deviant behavior is employed.

The basic concept is that we do not consider drug addiction as the whole problem. Our aim is to treat the underlying emotional disturbance of the addict, which often is an underlying sense of futility and dependency, but can also be related to a more complicated psychiatric condition. Being drug free is no big deal. Residents do that from day one of the program. The goal is to remain drug free by coming to terms with the cause of the problem and developing a commitment to upward mobility, first identify one's potential and then maximize that potential, regardless of how great or how little it may be.

There are three types of treatment modalities within the program.

1. The adolescent program for 13-17 year olds.

2. The adult program for 18 year olds and up.

3. The parent's program for single parents or married couples with children.

All three programs interact as one large extended family. The program has three phases - pre-treatment or motivation phase, the treatment phase and the re-entry phase, with each phase having three levels.

It must be noted that there is often overlap in these figures. The child abuse victim may also be psychotic etc.

Our figures show that 8% of those interviewed for induction are assessed as unsuitable to enter the Odyssey House program.

At the present time 10% of residents are on psychotropic medication, all of them for depression.

Our experience shows that if we allow the resident population needing psychotropic medication to exceed 20% of the total population it becomes disruptive and difficult to manage. Thus we have a screening out process which is rigidly applied in three categories.

1. Those who are acutely suicidal.

2. Those are acutely homicidal.

3. Those having a history of arson.

Anyone who is seen to be a potential danger to themselves or others is automatically referred through our psychiatric consultants to a more secure psychiatric setting whenever possible.

Close communication between the clinical staff at the House and the admission team is essential to determine what the climate of the House is as to whether we can make concession for a more disturbed person, following the common Therapeutic Community for the individual.

It is very positive, productive and highly therapeutic in the environment of the large extended family of the therapeutic community to teach that the healthier family members can look out for and make concessions for the not so healthy. Thus the anti-social personality learns care, concern and sensitivity, while the more fragile person benefits from the structure necessary to enable them to stabilize on medically supervised medications.

However, it is important not to create a situation where the staff's time becomes so taken up with the far more difficult individuals at the expense of the quality of treatment of the bulk of the population.

A tremendous amount of time and energy went into developing the repuattion and credibility of the drug free therapeutic community approach in this part of the world, for years blockade methadone was the only available treatment for drug addicts and there has been a strong lobby for free distribution of heroin for registered addicts.

Lack of facilitaies and basic lack of interest from the psychiatric and medical fraternity can create a situation where the therepeutic communities beocme a dumping group for psychiatric patients with secondary drug abuse problems.

Under the Victorian Drug and Alcohol Dependent Persons act of 1968 the only altaernative for the judge to recommend treatment was to the Government methadone program.

With this in mind we must we must be careful how we describe the use of medication. We have often found our drug free status naively challenged in public speaking situatioins because we allowed the residents to smoke cigarettes and drink coffee. This aside the fact is that we do not use any drugs for the treatment of drug addiction per se. However, we would not deprive a person of necessary medical attention separate and apart from their addiction whether that be physiological or psychiatric in nature.

Normally we would not detoxify addicts applying for treatment. We would encourage heroin addicts particularly to undergo "cold turkey" withdrawal, understanding that most of them can handle it and have had the experience numerous times in the past. (No-one has ever died of heroin withdrawal). Those who feel they need detoxification would be referred to a detoxification hospital prior to induction to Odyssey.

As in most things there are exceptions to this as well. Due to the tremendous lack of facilities we utilize short term detoxification supervised by our in house general practitioners in three situations and when external facilities are unavailable.

1. Barbiturate withdrawal - which can be fatal if not handled properly.
2. Pregnant addicts.
3. Adolescents - Odyssey has a 24 hour induction service. We never turn away kids.

<u>Assessment Procedure</u>

The consultant team consists of two sessional psychiatrists and two sessional psychologists who assess those people who are already resident in Odyssey House. The Clinical Co-ordinator, who is also a psychologist, liases between the staff and the consultants.

The co-ordinator is able to give the consultants feedback from the staff as to the person's behavior in the facility and is able to implement recommendations from the consultants in a way that is consistent with the structure of the program. The staff person at the Admissioins Center liases with a general practitioner and two psychiatrists in private practice, as well as with the Clinical Co-ordinator and the Clinical Director.

The assessment process begins at the Admissions center with a detailed interview conducted by a senior resident of the program. Information is obtained about the addict's drug history, employment record, criminal offenses and family relationships. The interview then moves onto gathering a history of previous treatment, specifically any psychiatric trreatment. The interviewer will at some point in the interview discuss what are called the four "red lights", which are attempted suicide, homicide, assault or arson. The red lights are referred to as such because it is a signal that a person presenting with a history of any of the above is unsuitable for the Odyssey House program. It is not uncommon of course for addicts to have overdosed or assaulted someone, however the purpose is for the interviewer to pass back the information which is evaluated firstly by the Supervising staff employed at the House. As will be appreciated, it is important to distinguish between the addict who accidentally overdoses and the addict who makes calculated and deliberate attempt to suicide. In our experience the latter type of person frequently cannot cope with the confrontational style of the Therapeutic Community, but rather needs a gentler, more supportive approach. Anyone who is assessed as being highly likely to act out upon themselves or others is offered referral to alternative psychiatric treatment. Where there is uncertainty regarding the evaluation, the person is referred firstly to a general practitioner who is part of our team.

The general practitioner acts as a further screen, as it is important to only refer on for a psychiatric assessment when necessary as there is a waiting period for such appointments. At that point, the district assessment would make a recommendation for either treatment at Odyssey House, or alternative referral. A further consideration in the close liaison between the external consultants and Odyssey staff, is the climate of the House. At some points when the mix of residents being treated gives a sound foundation and atmosphere in the House, the community can tolerate someone coming into the program whom we may later find psychiatrically unsuitable. At other times, if the community itself needs a lot of time then it may be decided that to admit someone who is only on the borderline of suitable is not in the best interest of the community.

To summarize, these kind of decisions are rarely clear cut and there are occasions when it may be worthwhile to give the individual a chance to prove themselves. It is a matter always of balancing the needs of the individual with those of the therapeutic community, bearing in mind that Australia generally has proportionally fewer alternative treatment resources than are offered elsewhere. The next step in the assessment process is that if the individual is accepted into the program, irrespective of previous psychiatric treatment, they will be evaluated by our consultant team. Sometime in the first four-six weeks, the individual will have a physical examination, will be assessed psychiatrically and given an intelligence test. Personality testing may also be done at this time although more typically that will be carried out later in the program. That information is then assembled and available to the staff who will run the resident's Probe group. The Probe is the "rite of passage" into the community, where the resident is asked to tell us as much about themselves and their past life as they can.

From the Probe group and the consultant evaluations a treatment plan will be formulated for the individual which is reviewed by the treatment team weekly, the full time staff monthly and by our extramural consultants every six months. Further referrals for more intensive assessment can be made at any time that problems arise with the individual that the full time staff feel some wish to have further input on. Most typically a resident will be referred for a medication assessment at the consultant psychiatrist by the consensus of the staff after the resident has been in the treatment phase for a period of time. As will be illustrated by these vignettes typically these are individuals who have demonstrated their motivation and willingness to address their personal problems by being in the program not less than three months and by participating to the best of their ability.

Psychotropic medication is seen as facilitating a person's progress and increased participation in the program. This is, it is our view that there are occasions where an individual cannot rise above themselves without assitance in the form of medications. It must be stressed that the expectation that an individual is responsible for themselves and their behavior is maintained.

The following case vignettes illustrate our approach.

Case No. 1

Ms. J.B. entered Odyssey House at 27 years of age in March 1983. At that time she had been caring for one child, while another child remained in the care of her mother. She had been to two detoxification centers previously and had convictions for prostitution and self-administration of heroin.

J. was the third of three children raised by her mother after her alcoholic father deserted the family during her childhood. J's. drug use began at 11 years of age with alcohol and progressed through adolescence to using an assortment of drugs until she began using heroin at 21 years of age. J. had been using heroin daily for six years prior to her induction to Odyssey House.

J. was highly motivated to complete the program, but very emotionally labile. She had difficulty settliing and was quite scattered in her thinking, which was reflected in her intelligence testing scores. J. tested as

having average intelligence, however she showed quite a wide range in performance. (Verbal IQ 104: Performance IQ 116) She was diagnosed as Inadequate Personality Disorder with neurotic depression.

J. was depressed about her inability to manage the demands of the program which confirmed her low opinion of herself. After a period of being drug free for three months it was evident that J. was unable simply to pull herself out of her present difficulties. She had been interviewed by the consultant psychiatrist on several occasions over the period and it was the opinion of both the psychiatrist and the staff that J. may benefit from medication.

Personally testing was carried out by our consultant psychologist who also agreed that a trial of medication may assist in stabilizing J's affect. J. was prescribed a tricyclic anti-depressant and reviewed regularly by the psychiatrist.

While J. remained a fairly emotionally fragile person, she was able to complete the program. During her residence in the program J. was also made a Non-Level Trainee, which is another type of modification to the program. NLT status means that the resident does not have responsibilities for other residents treatment. NLT status is used when an individual is of low intelligence or where an individual has fragile reality testing. In these cases it is felt that they should not be involved in giving therapeutic direction to lower house residents. It should be noted as in the case of J. that most NLT's compensate by working extremely hard in the areas where they do carry responsibility. J. has now been a Level IV graduate of the program for 12 months. She lives in a co-opeative with other graduates, has steady employment, which she enjoys and has been drug free.

Case No. 2

Ms. L. is a 29 year old woman with two children who entered Odyssey House in March 1948. L. is the first of four girls all of whom have used drugs. L's drug use began at 15 years with cannabis progressing through adolescence with an assortment of drugs.

At 20 years she commenced daily use of heroin which she continued for the next eight years until her induction into Odyssey. L. had previous convictions for theft, burglary and possession of drugs of addictiion. In the three years prior to Odyssey, she had made three short-lived attempts to remain drug-free at other treatment centers.

On entering Odyssey House, L. presented as a capable mother who was depressed. L's husband of eight years had committed suicide three years previopusly and it was evident that little of the grief of that loss had been processed. She was diagnosed as Antisocial Personality Disorder with distorted grief reaction. She is of above average intelligence. L's father had died during her adolescence and it was obvious that drugs had been a way to block profound feelings of hopelessness and grief. After a period of being drug free for four months, it was felt by the staff that L. should begin anti-depressants while she continued to work in therapy on her grief. Subsequently L's sister was murdered. L. is an extremely capable woman, and suffered from clinical depression. The medication lifts her mood sufficiently for her to be able to work in therapy and resolve her grief so that she will not need the medication in future. L. at present still had many issues to face, but she is a senior resident and gives a great deal to others.

Both these case vignettes illustrate situations where the resident requires medication for clinical depression only until they have resolved issues which led to the depression itself. There are also a very small number of instances where medication is required by the individual even after graduation and the person continues to required minimal psychiatric monitoring. The use of lithium for manic-depression or minimal amounts of phenothiazenes for borderline psychosis are examples.

In conclusion, it is worth reiterating thaat these are individuals who are unlikely to receive adequate treatment elsewher if they are turned away. We consider it is worth the effort of the staff and the therapeutic community to extend and reach out to those who are in a little extra difficulty.

A MULTIMODALITY APPROACH TO TREATMENT IN A THERAPEUTIC COMMUNITY

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"Addicts have too much eros and too little agape to begin with and much too short a dose of charis."
---Lewis Yablonsky, The Tunnel Back: Synanon, 1965

The therapeutic community (TC) has offered a global view of rehabilitation, where drug abuse and criminal behavior were signs of social disorder, family disturbance and individual maladaptation. It was thought that the TC provided a growth environment where the member could progress in emotional growth, from child, through adolescence to adult. Some have thought that the TC is a microcosm of society, where value contradictions, class disharmonies, socioeconomic inequalities, prejudice and sexual stereotyping may function as in the larger society. Paradoxically, the TC provides an elaborate surrogate tribal family that fosters identity, stability, growth and development. some have characterized the TC members as like-minded (Frye 1984a,b).

Although the term therapeutic community is generic, most American drug-free TCs for addicts trace the history of the modality to the early days at the Synanon facility in Santa Monica, California (Yablonsky 1965). A National Mental Health Team found a "miracle on the beach" there which showed success in treating the heretofore untreatable heroin addict (Bassin 1984). Public funding for similar programs subsequently became available. there TCs based on the Synanon model trace their development in one of two ways: 1) the East Coast Model pioneered by Daytop Village in New York City (developed by David Deitch, a Synanon alumnus) and continued by the founding of other TCs by Daytop's staff and graduates, and 2) the West Coast Family Model founded directly by other Synanon Graduates and Splitees (those who left without graduating). Examples of the latter were the Mendocino Family TC and the Napa Family TC in California. The major treatment tools of both models have been Synanon inspired and, with some modifications, have been confrontation group therapy, encounter or game; verbal haircuts or critical feedback to the client; cognitive concepts and seminars; a belief system emphasizing honesty, responsibility, self-reliance and trust; rituals and totems; and drug abstinence values. In addition, there has been limited differentiation between the care-giver and the recipient and rewards for "good" behavior and punishment or discipline for "bad" behavior. Therapeutic community leadership has often been charismatic, leading to increased group cohesiveness and member dedication (Frye 1984a,b).

Therapeutic communities were part of the multimodality programming for the treatment of addiction developed in the late 1960's as a response to the factionalism that had developed among different methods of treating opiate addiction. Early multimodality programming consisted of an organized system of clinics with a central intake unit and special support units under one administrative authority (Senay 1981). Along with TCs, multimodality treatment approaches included services such as detoxification, mental health counseling, group therapy, confrontation therapy, methadone maintenance, narcotic antagonists, vocational counseling, social work and religious counseling (Frye 1985; Veterans Administration 1973).

Outcome studies have shown the effectiveness of the TC modality (Frye 1984a), and length of time in treatment seems to be the major variable discovered which may predict successful treatment outcomes. Holland (1983) indicated that the next generation of outcome research should go beyond the question, "Does the program work?" to identifying how much change can be accomplished, with what types of clients and using which procedures.

In the past, the traditional resident in the TC has been the heroin dependent person. During the 1970's, stimulant abusers became representative in the TC population, and in the 1980's polydrug abusers are becoming as numerous as the opiate dependent person, bringing different demographics and characteristics. TCs are struggling to adapt to the special needs of managing the polydrug abuser. comprehensive treatment of polydrug abusers generally requires the strategic use of a variety of techniques (Frye 1984a).

It is the goal of this paper to present a multimodality approach to programming in a therapeutic community that will consider the special needs of the polydrug abuser. This approach is based on experience with multimodailty programming for the last several years in the Ayrie Therapeutic Community administered by the Veterans Administration Medical Center in Denver, Colorado. The Medical Center is unique insofar as multi-disciplinary professional and technical terms are available to work with the Therapeutic Community.

Theoretical Basis for Multimodality Treatment Planning

As Tiger (1979: 173) has pointed out, humans, being more complicated animals, must have more instincts than others, and "our brains are higher brains, more efficient at diagnosing and ferreting out possible hazards, impediments, problems (moral and factual) and demons and shades with which we can be harassed. It becomes all the more important then that we possess an overriding internal censor of all these

mean and depressing thoughts so that we are not immobilized and disconsolate forever." Addictions may activate the "overriding internal censor."

Charlesworth and Dempsey (1982) suggest that addictions are not a phenomenon of the few but a major phenomenon including many humans. These data suggest a need to find alternatives, rather than just abstinence. A void is created when an individual is asked to give up his addictive resources, whether it be alcohol, licit or illicit drugs, food, gambling, risk-taking, etc. Addictions appear to affect survival mechanisms which alter consciousness and are thus highly resistant to change through treatment (Frye 1980a). a multimodality treatment approach designed to address the problem of addiction may utilize submodalities or experiential therapies which may provide compensation for the lost addictive resource.

Two consonant hypotheses or addiction models are used as a theoretical basis for treatment planning. A sociobiologic theory of addictive behavior (Frye 1981a) is interdisciplinary and grounded in social evolutionary theory. This concept utilizes phenotype (observed behavior), genotype (heredity) and environmental factors (P=G+Ef). This theory hypothesized that the ability to withhold unpleasant sensations from oneself may permit the individual to take steps to overcome unpleasant stress producing stimuli. The sociobiologic theory postulates that addictive behavior patterns is a syndrome based on genetically adaptive behavior patterns and is a social behavior with biological foundations. The behavior alters the individual's çperception of stressful situations and promotes behavior change toward objects and circumstances in the environment that are perceived to be threatening. In the Milkman and Sunderwirth (1982) Interdisciplinary Addiction Model, addiction is defined as self-induced changes in neurotransmission which result in problem behaviors; and three addictive types are identified which cluster around excessive needs for "arousal," "satiation" or "fantasy" experiences. Using these two consonant addiction models as a theoretical foundation for treatment planning, a multimodality approach to addiction treatment involves developing programs to assist the client in acquiring skills. These skills involve learning how to cope with stress on an affective, cognitive, and behavioral level (Milkman 1983).

Multimodality Treatment Modalities

Affective Modalities. Affective modalities are biopsychological and stimulate a state of altered consciousness. It is thought that altered consciousness results from changes in neural/neurochemical mechanisms in the brain brought about by increasing or decreasing neurotransmission (Milkman and Sunderwirth 1983). Neurotransmission is subject to stimulation or demotivation and appears to be controlled by endogenous chemicals. Addictions appear to alter consciousness by changing levels of neurotransmission. Levels of neurotransmission may be modified by environmental factors, that totality of physical and social phenomena which surround or affect an individual. Perceived threats to an individual's survival or perceived safety and security are some environmental perceptions which may alter an individual's levels of neurotranmission. The ability to alter consciousness is a defense mechanism used by vertebrates which augments the organism's çevolutionary survival chances under circumstances in which a cold and correct environmental assessment might be sufficiently demoralizing to mean the difference between life and death (Frye 1984b, 1980a).

The goal of affective modalities is to train the client to achieve an affective experience which may alter consciousness and produce feeling, emotions, moods and temperament. Stress management training may be an appropriate modality for this purpose, and the training may involve a) visual imagery to produce cognitive calming, b) progressive relaxation to achieve a tension-relaxation contrast, c) verbal suggestions to achieve deep muscle relaxation, d) autogenic therapy promoting heaviness and warmth in extremities and calming of the autonomic nervous system, and e) automated systematic desensitization where the client imagines a hierarchy of anxiety- producing situations under conditions of physical relaxation with the goal of weakening the anxiety responses (Charlesworth and Dempsey 1982; Chaplin 1975).

Charismatic group therapy may be another affective modality which may alter consciousness (Galanter 1982; 1978). Often seen in drug-free TCs, Alcoholics Anonymous and religious groups, charismatic therapy may involve totemic objects and rituals with a behavior code. It is associated with a zealous movement and there is limited differentiation between the caregiver and the recipient. The group members adhere to a consensual belief system, sustain a high level of social cohesiveness, are strongly influenced by behavioral norms, and impute charismatic power to the group or its leadership (Frye 1981b; 1984). The altered states of consciousness produced by charismatic therapy appear to be similar to those seen in the religious conversion experience, and relief from depression and anxiety may be experienced ç by the charismatic group member (Galanter 1978).

Meditation is an affective modality associated with a decline in addictive behavior (Aron and Aron 1980). It usually consists of a sustained effort at thinking, usually of a contemplative variety. It may involve a mantra or sound pattern as an incantation. The physiological effects of meditation are opposite to those identified by medicine as being characteristic of the effort to meet the demands of stress (Selye 1975). Like drug-using behavior, meditation appears to alter the individual's perception of stressful situations and promotes behavior change toward objects and circumstances in the environment that are perceived to be threatening (Frye 1981a).

Alpha brain wave conditioning may be an adjunct affective modality in the treatment of addiction. A brain wave is the rhythmic fluctuation of voltage between parts of the brain. Clinical research has reported the correlation of alpha activity with subjective states of relaxation, peacefulness, etc. (Kamiya 1964). The

purpose of alpha biofeedback training might be the production of a standard stimulus-response association between alpha control, and anxiety reduction and anxiety reduction need not derive from the biofeedback in order to become paired with it. Biofeedback may be useful at an early treatment stage, but later stages must lead to the development of styles of thought and behavior fostering autonomy from existential crutches (Goldberg, Greenwood and Taintor 1977).

The Experiential Group Marathon may be an existential affective modality that can stimulate a state of altered consciousness and consists of a group encounter of extended length, usually of 24 hours duration or more. At the end of a marathon, individuals often feel they have gone through a unique, singular experience that makes them special (Cohen and Rietma 1980). The individual may report a changes state of consciousness (a "peak" experience). Active mechanisms in the marathon promoting altered affect might include sleep deprivation, stimulus intensity (sound, light), shared group closeness or cohesion and emotional release (Hoag and Gissen 1984; Frye, Hammer and Burke 1981).

Ericksonian psychotherpay may be an affective modality of use in the treatment of addiction. This modality uses resistance, symptom prescription, paradoxical double binds and strategic interventions with complex embedded metaphors, hypnosis and strategic use of trance phenomena (Erickson 1980; Lankton and Lankton 1983). Neuro-Linguistic Programming (TM) is based on Ericksonian techniques and may solicit affective change or altered states of consciousness (Grinder and Bandler 1982).

Cognitive Modalities. Cognitive modalities include didactic lectures, seminars, workshops and audio-visual presentations. When individuals receive adequate training in certain skills such as assertiveness, socializing, sexual functioning, or value clarifying, they often change their thinking, behaving and emoting, and sometimes make themselves less emotionally disturbed (Ellis and Grieger 1977). Studies have appeared that have demonstrated that skill training has therapeutic effects, and such training includes an important cognitive element (Byrne 1973; Christensen 1974; Usher 1974).

Cognitive-Behavioral Therapy may be a modality of use in the multimodality approach to treatment for addiction, and it has proven useful as an alternative and adjunct to traditional approaches. This approach includes assumptions that treatment planning includes the critical element of evaluating how the client perceives the effects of addiction and how the client perceives the reasons for addiction. The treatment planning may then explore alternatives and challenge misconceptions. Specific targets of treatment are identified by the client and therapist so that progress can be objectively measured. A target is defined as a problem area that is related to the addictive behavior (Weiner and Fox 1982).

Rational Emotive Therapy (RET) is a Cognitive-Behavioral Therapy that assumes everything people do includes very important learning elements. Ellis (1977) wrote that biological inheritance and self and social learning tendencies combine to make us human and to provide us with our main goals and satisfactions. We largely control our own destinies and particularly our emotional destinies by the way we interpret or look at the events that occur in our lives and by the actions that are chosen to be taken. Rational Emotive Therapy has utilized therapy groups designed for impulsive individuals and has been used to treat addictive behavior (Watkins 1977).

Behavior Modalities. Among the techniques available to the behavioral therapist are anxiety-relief responses, assertive behavior facilitation, behavioral rehearsal, conditioned suppression, covert extinction, covert reinforcement, emotive imagery, implosive therapy, replication therapy, self-desensitizations, shame aversive therapy, thought stopping and time out from reinforcement (Chaplin 1975). Behavioral therapies have been utilized as treatment for addiction and applies learning principles and techniques. It assumes that disorders such as addiction are learned ways of behaving that are maladaptive and consequently can best be modified in more adaptive directions çthrough relearning. A direct attack is made on the client's symptoms.

Aversive therapy is a behaviroal modality aimed at reducing the frequency of maladaptive behavior by associating it with aversive stimuli during a conditioning procedure. The use of drugs (antabuse), electric shock or other aversive stimuli may become paired with the addictive behavior. The addictive behavior becomes aversive and the client develops a repugnance for that behavior. Electrical and chemical aversion techniques may be difficult to apply to the typical addicted individual. Covert conditioning or sensitization has gained some accucing the frequency of maladaptive behavior by associating it with aversive stimuli during a conditioning procedure. The use of drugs (antabuse), electric shock or other aversive stimuli may become paired with the addictive behavior. The addictive behavior becomes aversive and the client develops a repugnance for that behavior. Electrical and chemical aversion techniques may be difficult to apply to the typical addicted individual. Covert conditioning or sensitization has gained some acceptance in the treatment of persons addicted to drug using and consists of the use of imagined scenes as aversive events and as rewarding events (O'Brien and Lorenz 1979; Callner 1975; Cautela and Rosensteil 1975; Chaplin 1975).

Discussion

While it is probably not feasible in a therapeutic community to include all of the aforementioned therapeutic modalities, it may be worthwhile to include at least one modality from each of the three major classifications: cognitive, affective and behavioral. In the Ayrie TC, this includes stress management training, TC membership, experiential group marathons, seminars, workshops, Rational Emotive Therapy (RET), positive and negative behavior reinforcement, psychotherapy groups, confrontation-sensitivity groups, Vietnam

delayed stress groups and contingency management. Addicted individuals comprise a wide range from various social classes, ethnic and geographical backgrounds, and no single program can meet the needs of all addicted persons. In recent years, a better understanding of the need for comprehensive, multimodality programs has evolved (Brill 1977). There is a need to focus on the individual as well as the addicted behavior.

Since polydrug, alcohol and other addictions permit individuals to cope by altering stressful environmental assessments and perceptions which may affect survival, successful treatment leading to cessation of that addictive behavior must consist of training in other, less destructive ways of coping.

As Tiger (1979: 173) has pointed out, humans, being more complicated animals, must have more instincts than others, and "our brains are higher brains, more efficient at diagnosing and ferreting out possible hazards, impediments, problems (moral and factual) and demons with which we can be harassed. It becomes all the more important then that we possess an overriding internal censor of all these mean and depressing thoughts so that we are not immobilized and disconsolate forever."

Addictions may activate the "overriding internal censor" by causing changes in neurotransmission promoting a feeling of well-being and optimism. Addicts may perceive environmental deficits which need to be filled by satiation; environmental excess which needs to be confronted by arousal; or environmental existential quiescence which needs to be altered by fantasy.

Treatment for addictive behavior may need to consist of a multimodality approach aimed at a) using cognitive and behavioral modalities to achieve abstinence from the behavior or modification of that behavior; b) using affective modalities to substitute other behaviors to help fill the void created by abstinence; and c) using cognitive, behavioral and affective modalities to provide skill training in altering consciousness to overcome perceived environmental impediments on a long-term basis.

According to long-term observations by this author, most if not all successful therapeutic community graduates have found substitutes to fill the void caused by abstinence from drugs including alcohol. These substitutes, or alternatives to taking drugs, involve techniques to alter consciousness -- to "get high" naturally. According to Weil and Rosen (1983; 170), "There is growing evidence that high states are crucial to well-being. People who learn to change their conscious experience in safe and positive ways seem to be the better for it. They are healthier physically and mentally, more creative and productive, contribute more to society, and are more fun to be around."

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WORKING WITH MINORITIES IN THE TC

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Let me begin by expressing my gratitude to the World Conference of Therapeutic Communities and to Walden House for inviting me to attend this conference, and for allowing me the opportunity of participating in this cross-cultural exchange of ideas. I would also like to give special recognition to Charles E. Dederich and the people of Synanon for having the courage of their respective convictions which, in my opinion, provided groundwork and structure for a majority of the therapeutic communities in existence today.

I feel a sense of kinship with all of you here, because although we may follow slightly different paths, the goal that we aspire to is essentially the same. I would generally describe this commonality of purpose as the creation of environments which encourage personal growth through psychological, social and political insight, support for behavioral change, and at its' very best, providing each individual with the opportunity for finally taking possession of his or her own life.

I would like to direct your attention to the issue of culture as it pertains to this relatively new therapeutic community movement. The mental health field has traditionally seemed to view culture as being either too complicated to deal with, or therapeutically unimportant. Now, it has long been a given that culture, with its many definitions, is vital in shaping our perceptions. Therefore, this resource, whether acknowledged or not, must play an integral part in any process that aspires to be of therapeutic value. It is this issue of culture and my concern for seeing it consistently included as a priority in the design of treatment programs in general that will be the focus of my attention during this presentation. My own experience has been working in a majority White culture with White, Black and Latino clients in the United States for approximately 17 years. I will present from this experience, but will encourage you to draw specific analogies and make appropriate applications as they pertain to the cultural representation of your respective communities and countries.

Most often in therapeutic communities, the concept of "Family" is a crucial and primary learning experience taught to incoming residents. The familial atmosphere is designed to provide a sense of warmth and belonging to those involved, making it possible for them to share more intimate details of their lives in a less threatening environment. It is easy to see the importance of this, because it encourages interaction early in the therapeutic process. By the creation of a family culture, we also facilitate control of the population by establishing fundamental behaviors and values that the entire family are required to accept and respect. This experience is not unlike the primary acculturation which occurs early in the development of each child and eventually shapes perceptions.

With this in mind, it is my opinion that culture is essential, not only in the development of each human being, but in the orientation of new residents in a therapeutic community as well. Of course, the cultural bias will favor the majority population represented in this "family"; staff and residents alike. However, this orientation is an extremely sensitive issue because the healing process takes place only in direct proportion to the resident`s ability to adapt to the majority culture of the community. Consider for a moment, minority clients who must appear to disassociate themselves from their adaptive cultural perceptions in order to qualify for membership in this lifesaving system. This required assimilation, which necessitates a betrayal (either actual or contrived) of deeply rooted cultural values is, in my experience, destructive to the personal growth of minority group individuals. On the other hand, remaining loyal to cultural values and mores is most often misinterpreted and reacted to as resistance, the consequences of which are equally devastating, (i.e. increased insensitivity, alienation from the family, etc.). This double bind places the client in a situation where loss rather than gain is inevitable. A disclosing/non-disclosing duality has been created. This, unfortunately, is all too reminiscent of the institutional and systematic attempt by White people to belittle and obscure the rich cultural heritage of minority people in America.

This duality places the minority resident in a "no win" situation, especially when one considers the weakened state of any client seeking help from a treatment facility. The non-disclosing minority clients who are capable of pretending to disassociate themselves from their culture, have in fact merely relegated themselves to "gaming" through the system. This is true, even of those who appear to have become successfully assimilated into the family. If these non-disclosing clients are understood by the environment, they are considered insincere, and this insincerity will eventually become their undoing. If they are misunderstood, they will be considered model clients, and have to live with the guilt that arises from that deception. They in fact have short changed themselves, and traded comfortability for the illusion of status. This guilt, of course, like most guilt, is extremely hazardous to the client.

Conversely, the clients who select to disclose suffer because their world view is quite different from that of the majority population. When they speak of anger, frustration and suspicion, they will typically be accused of senseless hostility, naive expectations and paranoia, respectively. All of these are examples of deficit model interpretations of, what are in fact, healthy reactions to the majority culture world view. To be misunderstood in this way is predictable and familiar, although frustrating and painful to say the least. For

minority group people to disclose and be understood is perhaps the most lethal of all possibilities, although it is typically seen as the ideal from a majority group perspective.

For example, when a Black client is asked to fully disclose to a White therapist even with the best of intentions, there is, in my experience, an almost unconscious counter-reaction which will inevitably leave the client feeling a sense of guilt and cultural betrayal once the disclosure has been made. This aspect of the cross-cultural trap is particularly complex. The client's fear of loss of control to a member of a society which he has learned to perceive as racist will exceed the boundaries of what is considered usual. This is exacerbated by history to the degree of suffering that this person has undergone solely by virtue of his ethnicity. He has in fact lost possession of his soul.

It is for these reasons, and others that I unfortunately do not have time to address today, that I feel that one of the most important priorities in the design of an effective therapeutic community must be consistent emphasis on the cultural and class aspects of the minority groups represented, or potentially represented, in that community.

My experience has taught me to be somewhat cautious in regards to presenting possible solutions for these problems to majority population therapists. Thomas and Sillen state in their book Racism and Psychiatry, that, "It is arrogantly ethnocentric to judge other cultures according to the degree to which they deviate from one's own". It is this arrogance, both conscious and unconscious, that makes any viable solving of these problems particularly difficult. The best minds in the academic community seem to address these issues by invoking the myth of "color blindness". Simply put, this approach seeks to render the impact of racism on a minority individual's personality as illegitimate and nonexistent concerns, which are overshadowed by psycho-social phenomena which the majority population view as central. Again, perception as it is shaped by culture is crucial here. Without becoming intimately involved in the rich and fascinating world of non-ordinary cultures, it is highly unlikely that majority population therapists will broaden their own cultural perceptions to a great enough degree to be able to understand, respect or effectively deal with minorities.

However, since nothing beats a try but a failure, I feel that the necessary commitment is clearly apparent. We must commit ourselves, Black, White, Green or Grizzly, to becoming truly multi-cultural in order to effectively serve our varied clientele. The bridge is to be willing to scrutinize our programs with an eye towards enhancement through a concern for culture as well as behavior modification. This step can lead from a philosophy of talking, and abstract rhetoric, to a philosophy of action. This action can take the form of searching outside of an incestuous, closed system for qualified, bi-cultural therapists who are capable of supporting a staff in broadening their individual cultural perceptions, and becoming sensitized through seminars, workshops and staff group interactions on a consistent basis. The degree to which this is possible will depend entirely on the strength of purpose and commitment of the individual therapists involved. I think that each of us can be fairly judged by the intensity of this commitment, because it is the responsibility of the therapist to be consistently involved in the process of growing and becoming. Do not make the mistake of confusing bi-cultural with simply being a member of a minority culture. If individuals are not sensitized to the special needs of any culture with which they come in contact, they have a responsibility to learn as much as they can about the differences. The similarities are self evident. If therapists are not willing to take this responsibility, they should, for the sake of integrity, step out of the way and allow those who are willing to take the responsibility share in this special privilege. By dealing with a clients cultural perspective, we can gain access to his psychological processes, and herein lies a resource which only the most dedicated should engage.

By this time I would hope that it is absolutely clear that only bi-cultural minority group workers should attempt facilitating the specialized arena of the minority therapeutic group. This, once again, is not simply a matter of skin color or ethnic background, but requires true cultural sensitivity. For example, to be a person of color in America does not automatically mean that this person is familiar with the basic assumptions or subtleties of meaning inherent in a culture. Therapeutic groups for Black minority clients, for instance, are most effective when the Black therapist is capable of collaborating individually and collectively with the clients. This is often the first time these clients have experienced disclosing their feelings in an atmosphere which seeks to dignify them.

When a staff is sensitized to cultural issues, and trust is established, as a side effect of dedication and commitment as demonstrated by hard work in the aforementioned seminars and workshops, only then is the stage set for comprehensive work with minority clients. In this way, minorities can be engaged, and rapport can be established at the very beginning of treatment. As you well know, the rapport can be transformed into trust, and in any therapeutic environment, trust is the key.

I would hope that nothing of what I have said here today has lead you to believe that I am trying to push majority populations away from dealing with minority populations. On the contrary, my intention has been to hopefully shed some light on an old and very sensitive and complex problem which, in my view, is crucial to the further growth of the therapeutic community movement. I am personally committed to what I have shared with you today, and I am at the service of anyone who shares this commitment.

THE GROUP PROCESS WITHIN THE CONTEXT OF THE TC

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This paper is a beginning in regard to conceptualizing the group process as it occurs in the context of the therapeutic community. It is concerned with identifying and examining at least some of the underlying dynamics that occur on different levels. It addresses the process as a safety valve mechanism, as a check authoritarianism, as a mirror, as projection, as the search for truth, as the assertion of self, as the discovery of personal power, and, finally, in the context of the game. It also considers who is ultimately responsible for the growth, or lack of growth, of our resident populations.

Any attempt to conceptualize an experience has an inherent flaw. It is an attempt to communicate on the level of rationality what was originally communicated on the level of experience. Although one can move from the level of rationality to the level of experience to produce an expansion of communication, moving in the opposite direction usually produces a constriction, unless there has first occurred a shared common experience. Hopefully, most of us attending this conference have shared experience of the group processes in the context of the therapeutic community. Therefore, it is hoped that this paper will produce an expansion of our communication.

You will notice that there are not voluminous references and footnotes. In preparing this paper, I tried to rely primarily on looking at, and coming from, my own experience, rather than relying on what others, who may or may not have had an experience with the group process, might have had to say about the subject. I realize, as I am stating this, that this will probably be interpreted by some mental health professional somewhere to illustrate that those of us in the TC movement really are an arrogant lot. I'll take the risk.

Historically, the process, as developed and evolved in the therapeutic community, came out of an essentially pragmatic approach, during which there was continuing feedback about whether it was working. There was a great deal of intuition involved in the early development of the group dynamic and little or no rational processing of how or why it seems to be valuable. Only in recent years has there been any intellectual processing of the experience. This paper is an attempt to move further in that direction.

I have been using the word process in the title of this paper and in the preceding paragraphs for a particular reason. I would like to take a few moments to discuss what I mean by process as distinct from content. The dictionary defines process as a systematic series of actions directed to some end. I think that what is important about a process is that it leads to a desired result or goal. Process is concerned with the system. The content refers to what the series of actions looks like in detail, that one takes to reach that goal. In this paper, my primary focus is on process rather than content. The content can vary in relation to personal incli-nations, cultural, ethnic, age, and educational considerations, and severity and nature of pathology of the residents served. Process is primary. Content is secondary to process.

The proliferation of therapeutic communities world-wide over the years has created a wide spectrum of "contents". Various "therapeutic tools" may have a different appearance from T.C. to T.C. but, hopefully, what unites us all is a common process leading to some common goals - the empowering of our residents and, coincidentally, ourselves, by changing self-destructive thinking and behavior patterns, teaching personal responsibility, changing negative self-image, creating a sense of human community, and providing an environment in which human beings can grow and take responsibility and credit for that growth.

I suppose that, at this point, I should take a stab at describing what it is that I mean by "the group process," so that we can assume that we are talking about the same thing. The group process has been called many things, including "a synanon," "a game," "an encounter group," "a T-group," etc., etc. what I mean by "group process" is a leaderless group that usually occurs several times a week in the context of the therapeutic community. To say it is leaderless is not to say that there should be no officially designated leaders, as this usually results in the group process serving the egos of the designated group leaders rather than serving the residents as it was originally intended. Leadership emerges in a natural manner and will also be passed back and forth. In such a group, anything goes except acts or threats of physical violence. There is freedom to express one's feelings and thoughts. All members have equal rights in such a group--there is only personal status. One cannot use or hide behind vested status. If you are an authority figure, you do not get to wear your "hat," or title if you will, in the group setting. You assume the leadership of the group as a function of your capacity to lead, not as a consequence of your "label" or position in the community hierarchy. This means that everyone is a participant. No one gets to exempt himself or herself from the process.

On the designated days (usually three times per week), the "Group-Master" or "Guru" would break down the entire population of that facility ("staff" included) into encounter groups of 8-10 individuals. These groups were not open-ended. They had a time-frame to operate within, usually one and one-half hours. The Guru organized the composition of these groups with certain considerations in mind. Generally, his or her first consideration was to honor any "slips" that had been dropped by residents. A "slip" was simply a piece of

paper with two or more names on it. It was a device for requesting to be placed into a group with certain other individuals, usually in order to confront those individuals about some piece of behavior or attitude. The Guru then worked toward making each group a cross section of the resident population in regard to chronological age, sex, ethnicity, racial background and age in the T.C. Each group had several older (age in T.C.) and responsible members of the community. This was called providing "strength" in the group. These older and more responsible members were not officially designated as group leaders, although they may have been staff members. The "strength" in the various groups were, generally, briefed on what "slips" had been honored in their respective groups by the Guru, so as to insure that these confrontations were facilitated. These groups did not have a static on-going membership. The composition of these groups changed from group meeting to group meeting. Over time, every resident and staff member was afforded the opportunity to interact with and receive feedback from every member of the T.C. in that particular facility in a very direct and ritualized manner. The basic therapeutic approach in these groups was personal confrontation.

I realize that this confrontational approach, over the years, has been as passionately condemned as it has been supported. Without becoming involved in an extensive debate in this regard, I would like to make a couple of points about the confrontational approach. First of all, confrontation, like any therapeutic tool, must be wielded with good judgment in relation to the nature and type of population being served. Secondly, this confrontational approach needs to occur in a context of respect, caring, nurturing and support - lots of support. Context is everything.

When I began to examine the group process, I was struck by the complexity of the process itself. There are various dynamics occurring on various levels. It is akin to peeling away the layers of an onion. The purpose of this paper is to identify and begin, at least, to conceptualize some dynamics that occur at different levels, so as to open a dialogue rather than to make someone else wrong.

The Process as a Safety Valve

As most of us well know, living within a therapeutic community setting is an intense experience. It is designed to be. In addition, it is structured to make it extremely difficult to escape from that very intensity. There is virtually no refuge short of leaving the community. As a new member of the community begins to experience the intensity inherent in living and working in a highly structured and demanding community, feelings of frustration, anger and hostility surface rapidly. Make no mistake: this is intentional.

As Charles Hampden-Turner so aptly points out in his book Sane Asylum, describing the Delancy Street Community.

The strict regimen, the confusion, the hard menial work of the early weeks are deliberately designed to precipitate explosive Games. The sooner someone's genuine anger and emotion have been registered and recognized, the easier it is to deal with the incredible tangle of lies and self-delusion with which newcomers strangle themselves. Residents cannot begin to deal with each other's problems unless the habit of authentic externalization is quickly established.

The roars of rage are also, perhaps, the only possible introduction to the world of feeling. As residents develop, they are able to express many different feelings of great range and sensitivity. But for the newcomer, and especially for the male newcomer with his macho image, anger is the only acceptable feeling and it serves as an outrider for all the rest.

Now that we have caused these rather strong and intense feelings and emotions to surface, we must provide a way for them to be handled. Since the expression and acting out of this anger and hostility in the normal course of getting the job done in the T.C. is strictly proscribed, for obvious reasons, it is imperative to provide an arena for these feelings to be expressed in a manner in which no one is truly harmed. The group process functions here on the level of safety valve. It is an appropriate and safe arena for the "blowing off" of hostility, anger and frustration. It is a ritualized and essentially harmless form of verbal violence as an alternative to physical violence is no small matter, considering that many of our residents have long histories of physical violence and abuse.

In the process of waiting to handle one's feelings in the appropriate arena, the resident begins to learn about delaying gratification and exercising self-control.

The Process as a Check on Authoritarianism

We have all heard the assertion that power corrupts. Power tends to corrupt when it only flows downward from its source. The group process provides and supports the opportunity and vehicle for power to flow upward from its objects, specifically the individuals most affected by that power.

The group process can provide very direct feedback to those individuals in authority concerning their performance and the effect their exercise of authority has on those they supervise. The abuse of authority or power is extremely difficult to hide in a community that provides a mechanism for magnifying and closely examining abuses. Since individuals in authority are prohibited from wearing their "hats" in a group, an individual's status in the work or job hierarchy means little or nothing in the group setting. Authority figures are further prohibited from seeking any sort of revenge outside the group setting for something that

might have occurred within the group process. The group setting allows authority to be challenged and checked without destroying it in the process.

The Process as a Mirror

Every time an individual participates in the group process, he is afforded a special opportunity, whether he wants it or not, to see himself from as many different vantage points as there are other participants in the group. One almost literally can see oneself through the eyes of others. There is a very direct and intense feedback about how you present yourself which is extremely difficult to evade. Every detail of your life and how you handle it is under the closest scrutiny in a T.C. What makes it especially powerful is that this feedback comes from significant others, i.e., the individuals who one lives and works with.

Walter Kerr, renowned drama critic for the New York Times, in his review of the play The Concept created by residents of Daytop Villiage, shows a great deal of perception in writing about the process: "... the people on stage have long since taken themselves out of themselves for a good look, held themselves up like art objects to be examined objectively, dispassionately. They have recognized themselves by taking one giant, wrenching step backward from their earlier adopted skins, from their postures, their rationalizations, their habits, their self-portraits. A bold degree of detachment came into being while they were curing themselves; it was the principal thing that cured them."

The Process as Projection

Most of us are familiar with the concept of projection and its important role in the group process as we know it. What I mean by projection is the ascribing to others the feelings, attitudes, desires, and thoughts we have or have not identified in ourselves. Since the individuals assuming the leadership of the group process at any given time are not traditionally educated professionals, they have a distinct tendency not to operate from intellectual constructs about what is occurring with the other person. Insights about what is going on with the other or what the other needs at any given time come out of their considerable ability to empathize and take the role of the other. They come from their personal experience. On the level of projection, knowing the other is a function of knowing oneself. The one gaining the deepest personal insights from this projection interaction is the one doing the projecting.

As Dr. Lewis Yablonsky wrote in his article, On the Anti-Criminal Society: Synanon, in the September, 1962, issue of Federal Probation, "The group sessions do not have any official leader. They are autonomous; however, leaders emerge in each session in a natural fashion. The emergent leader tells much about himself in his questioning of another." Chuck Dederich, in his paper Synanon Foundation, appreciated and understood the importance of projection: "By virtue of an empathy which seems to exist between addictive personalities, they are able to detect each other's conscious or unconscious attempts to evade the truth about themselves.

The temporary leader leans heavily on his own insight into his own problems of personality in trying to help the members to find themselves, and will use the weapons of ridicule, cross-examination, hostile attack, as he feels inclined. The temporary inquisitor does not try to convey to the other members that he himself is a stable personality. In fact, it may very well be that the destructive drives of the recovered or recovering addictive personality make him a good therapeutic tool--fighting fire with fire."

The Process as the Search for Truth

Many of us have heard of truth in lending. What I want to address here is truth in feeling. The process as the search for truth is about absolute honesty in regard to feelings. No compromises are accepted.

It seems that one by-product of the socialization process in the western culture is a shift away from directly experiencing feelings to a rationalizing of feelings, so that they are filtered and censored before they are expressed or communicated. Often when you ask someone how he feels, what you get is his thinking about how he thinks that he should feel. Somewhere in this complex process, we lost the ability to tell the truth about, and connect with, how we feel. For most people, this incongruity, this lack of connection to feelings, does not seem to create a serious problem, although the price paid is probably as dear as it is subtle. For the people who seek us out, it seems to play a part in or contribute to their drive towards self-destructive behavior.

If one looks for truth in the group process regarding the facts and specifics of incident, one will look in vain. There are here and there one or two facts but the details of an incident are usually exaggerated to bigger-than-life proportions, which makes it difficult to tiptoe around them or to act as if one does not understand them or to pretend that one missed them somehow. What one can count on being true in a group, however, are the feelings. It is also an arena that asserts the validity of one's feelings within a larger culture that continuously invalidates one's feelings and ultimately, one's humanity.

The process on the level of the search for truth is about saying the unsayable, speaking the unspeakable. For many, it may well be the beginning of bringing to the surface material from the unconscious that could not be expressed elsewhere. Walter Kerr, in his review of the The Concept, made an interesting and insightful observation about the group process: "Encounter (is) a group session in which the participants fiercely and deliberately attack one another not for their failings but for their lies about their failings. . .

The Process as the Assertion of Self

If we take the time to look at it, we will notice that most of our residents come to us stuck in their fear about their own insignificance. It is the secret that they fear that the rest of us will discover. Charles Hampden-Turner's Sane Asylum paraphrases Mimi Silbert on this point:

" . . . Most residents in their early months are, in fact, consumed by self hatred." Although sociopaths are often said to be conscienceless, Mimi Silbert contends that their guilt is, in reality, as strong as it is deeply repressed. The volcanic eruptions within the Games help to spew the guilt forth, while the name calling actually makes contact with the image that the individual has of himself in a way that the soothing assurances of most professionals can never do.

The group process then becomes the vehicle by which the new resident can begin to externalize the anger, hostility, and hatred that he previously directed towards himself. In the process of confronting or attacking another effectively with the group setting, one has to shift from being nobody to being somebody. One cannot deserve to feel angry unless one is somebody. As the resident develops and begins to assume some leadership in the group, he must begin to embody the role of leader, teacher, therapist, wisdom incarnate, and, in general, role model. One cannot do this from a position of nothingness. According to a Synanon brochure, Synanon Games are fast paced and exciting, with frequent wild accusations, screams of rage, and peals of laughter. Each person's decision to involve himself in a fight for his own self-image and dignity demonstrates the sportsmanship necessary to the Game."

The Process as the Discovery of Personal Power

The process on the level of personal power is concerned with responsibility. Generally speaking, our resident population has demonstrated a great capacity for dishonesty with themselves and with others in regard to personal responsibility. Consequently, they have been able to take refuge in their own powerlessness. They seem to experience life as a series of things that just happen to them and which have no relationship to them as actors.

In the group process the emphasis is on the here and now. The group participants are not really interested in the "whys," but rather what one is going to do about them. The "whys" are usually used to externalize the responsibility for how one got where one is and, as such, are not acceptable. What is demanded is the telling of the truth about who is responsible. The choice to accept responsibility for how one got into this mess in the first place is the beginning of the realization of one's power. The next step is to realize experientially that one is powerful (responsible) for where one will be next.

The Process as a Game

The group process should also operate on the level of a game. I mean to advocate such a context. Operating out of a context of the game has some definite and beneficial consequences. It serves to increase and expand the sense of a safe space. In the context of a game, there is a lessening of the fear or anxiety that one can truly be hurt or destroyed. After all, it is only a game! On the level of game one can more readily begin to learn to "play with" strong and intense feelings and emotions instead of being overwhelmed by them. It becomes less threatening to begin to tell the truth about oneself to oneself. It is easier for one to begin to try new roles as well as new and different ways of being. Finally, on the level of the game, there is a potential for detachment about who one really is that ordinarily would not exist.

It used to bother me slightly that in some circles the group process is and has been referred to as a game. There was something irreverent there which made me uncomfortable. After all, we are dealing with people's lives, we are dealing with treating people, we are dealing with people getting better, recovering, growing, etc. This is all very serious business, or is it? There is the danger in all this seriousness that we will begin to take ourselves too seriously, so seriously that we might begin to believe that it is we who are responsible for the residents' growth, that somehow we caused them to grow in spite of themselves. Nothing could be more dangerous or demeaning to our populations and, ultimately, to ourselves. If we're lucky and we work real hard, we can create the climate in which individuals choose to grow and become responsible for their own growth. The context of the game would definitely be appropriate in reminding us to lighten up.

Some may consider this effort a back-looking journey into our past and I suppose that in many respects it is just that. I happen to believe that it is essential to understand and appreciate where we came from in order to move forward in a way that we don't become lost in whatever the current, continually changing, rhetoric and fads happen to be. In order to avoid this trap, I maintain that we must better understand what is valuable and, what is not, in the roots from which the T.C. movement has grown. The roots that set it apart from more traditional approaches to residential treatment.

I am not opposed to change and exploration of new possibilities. My concern is that in our desire to be recognized and accepted by the larger mental health professional community, we end up settling for style rather than substance. Some of us never really understood and appreciated the substance, but rather only learned the style and thought that we had gotten all there was to get. A good understanding of the process, its uniqueness, substantive value and how it works, frees us to build on it, to change it without destroying its

value and to have fun playing with the content. It is my hope that this paper has contributed in some small way to further expanding our understanding of one element of this process and to stimulating more dialogue.

I believe that what sets the T.C. approach apart from other therapeutic approaches, namely, the "medical model," is a process that is about empowering people rather than diminishing them. It is difficult, if not virtually impossible, to be empowered while being forced to play the role of "patient." In the T.C. process, we have managed to bridge the dichotomy between the therapist and patient, "teacher" and the "student." The process is at its best, when the "teacher" is also the "student" and the student is also the teacher and that the teacher models what he or she is attempting to teach..

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ADDICT RAGE - A THERAPEUTIC DILEMMA

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Once Abraham Maslow paid a visit to Daytop Village, a therapeutic community located in New York City. He commented: "The process here basically poses the question of what people need universally. It seems to me that there is a fair amount of evidence that the things people need as basic human beings are few in number. It is not very complicated. They need a feeling of pro-tection and safety, to be taken care of when they are young so they feel safe. Second, they need a feeling of family, clan or group, or some thing they feel they belong to by right. Third, they have to believe people have affection for them, that they are worth being loved. And that's about it ... could it be that Daytop is effective because it provides an environment where these feelings are possible? (Maslow, 1971).

Individuals arriving for treatment at therapeutic communities arrive through a variety of referral sources. Whether directed by the courts, probation or parole departments, social service agencies, churches or families, they all have "bottomed out." That is, they have exhausted all their means of supporting their compulsive drug taking and are now in need of treatment. They are usually full of remorse and emphasize the negative aspects of their addictions. However, after the detoxification phase is completed and early attempts at therapy have begun, the residents recall their addictions with a more romantic flair, conveniently forgetting the dysphoric aspects of their compulsions. (Marin, et.al. 1976)

The therapeutic community will provide (as described so well by Maslow) an environment that encourages responsibility, honesty, and integrity, with a clearly defined structure that will nurture and care for the resident in a way which will precipitate the deep and always painful exploration into the factors that contributed to the development of a compulsion to use drugs regardless of the dire consequences which too oftentimes include death. The therapeutic community will provide, perhaps for the first time in the drug user's life, a person who will empathize, encourage, validate, confront, limit set, and generally provide an emotional climate that will help the drug user to explore his/her psychological workings in order to provide a roadmap that the addict can use, not soley to "straighten out," but as a future guide to a full and productive life.

Yet, a certain impasse oftentimes develops between the new resident, the community, and her/his counselor. His/her view of the world is tainted with shades of mistrust. The world had been a hostile, unforgiving place where one took what one wanted. Nobody had ever given him/her anything without motive. Deep down she/he is very angry at these circumstances, and this anger can permeate the individual's total therapeutic community experience in a negative way. It sets him/her aside from her/his peers. He/she becomes the community scapegoat and group's object of focus and frustration. The compulsive drug user rejects the care and concern of the community and moreover blames the collective for its shortcomings as the reason for his/her state.

The most unfortunate consequence of this behavior is the strong negative feelings that result within the therapeutic relationship. The counselor is caught in an angry countertransference brought on by his/her feelings of helplessness and defeat.

Why, one might wonder, should an individual who is welcomed into the family of a therapeutic community act in such a manner as to reject the very milieu that is the prerequisite of her/his recovery? The answer to this and other questions related to the drug abuser's behavior is that the drug user has, due to his/her limited experience, a very limited number of options to choose from. In essence the way she/he acts is the only way he/she knows how to act. The behavior has become a defensive adaptation that is woven into the personality.

The drug has subsituted for the intimacy of relationship so the when the individual must maintain intimate relationships within the open structure of the therapeutic community she/he responds with a complex set of defenses and affects that have little or nothing to do with the current circumstance. Wurmser (1974) claims that drugs create within the inner life of the user an artificial or surrogate defense against overwhelming feelings. Thus, thinking has begun to change. Instead of drugs being an escape from reality, they are used by the abuser as a costly adaptation to the stresses of reality. It is, in essence, an attempt at self medication and should be viewed as such, without judgment of condemnation.

It is beyond the scope of this paper to begin to explore recent writings in the literature about narcissistic and borderline pathologies and their relationship to the treatment of compulsive drug use. However, it is important to realize that the drug has become for the individual user the lost object which should have provided the physical and emotional stability for a normal, healthy maturation. The loss leaves the individual with a strong rage reaction, usually blocked with significant depression and defended with a series of primitive defenses. If the individual addict allows her/himself to really feel the care and concern of his/her counselor and peers, then the devastation of the object loss would be complete and undeniable.

Once the counselor understands that she/he is operating within the transference field, then the behavior becomes understandable and open to a variety of therapeutic interventions. As mentioned, the compulsive drug user views the world as alien and hostile, making it difficult to trust, especially with the vulnerable feelings related to the repressed rage of the object loss. The counselor then must become for the drug user a "model" – someone he/she can idealize, respect and trust. The counselor must be consistent, genuinely interested and concerned with the recovery of the abuser, and demonstrate the important combination of care and limit setting. As the therapeutic relationship develops there will be numerous situations which trigger primary process rage reactions. For example, a denied pass, an unwelcome job or bed change, disagreement with peers, and especially conflict with "authority figures" can be used to work toward discharges of primary rage. First the here and now anger should be explored and discharged. These scenarios should never be viewed as games but rather as conduits leading to primary process issues.

Therapists and counselors unfamiliar with the depth and breadth of the feelings involved with this level of discharge would be well advised to seek out and work on these issues themselves in order to avoid the possibility of "rescuing" the client from these pains via avoidance.

There are various techniques that may be used individually or in tandem to help the drug abuser discharge these strong affective states. Djalaji (1978) found Bioenergetic Therapy helped reduce anxiety and lift depression for drug abusers when compared to those who received only talk therapy. The use of psychodrama has proved an effective tool to help individuals release long repressed emotions. The method is less important than the level of competence and understanding of the practitioner. It is during these sessions that the therapeutic alliance is well developed. After these discharges clients are quite vulnerable and open. It is at this time that the counselor provides the corrective emotional experience for the client, allowing she/he to grieve for his/her lost object. The occurs while providing the structure and safety to begin the formation of a self that can tolerate these affective states without the auxiliary ego called drugs. Thus the rage is used to help her/him become vulnerable and experience that state without being hurt, humiliated, subjected to abuse.

The result on the individual is immediate and apparent. There exists a congruency between words and deeds that did not exist before. The depression that was pervasive begins to lift and the individual begins to take a more responsible role within the structure of the community. One notices their participation in group to be more of a personal sharing than a pontificating. Most important, the individual realizes just how important the drugs were to him/her as a self administered medication. Once this level of awareness is reached the individual is on the road to life long exploration.

Working with the primary rage of these clients is no panacea, and must be integrated into a treatment milieu that includes vocational and educational development, family treatment, and an overall structure that increases responsibility. Thus the addict rage is converted from a ticket back to the destructive life style to an opening up to the strong possibility of a fruitful, productive life.

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LEAVING THE TC: FANTASIES & EMOTIONS

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Disturbances in the Process of Separation-individuation

I think that what our psychotic residents show us are the disturbances in a certain phase of normal psychological development. The normal development has not happened due to several complicated reasons, the affective atmosphere prevailing at home, and the singular characteristics of the child in question. Inside this intricate matrix where many histories and different related factors meet, is where the conditions for a normal transit through each moment of development takes place - or not.

When, due to different reasons, any component in that matrix is altered in the critical moments of development, a deviation occurs, and more or less serious consequences will inevitably appear through the whole vital cycle of the person. By "critical moment" I mean the one which, necessarily and in a substantial way, is basic to the fulfillment of a determinate function such as support, idealization, etc.

Using a metaphor, we conceive the psychological development as a train that starts from a definite point and has a destination. Along its way, the train goes over determinate stations at determined times. It doesn't stop except at those stations and times. It remains at each stop for a certain period and then continues its way until its final destination is reached.

The phase that M. Mahler (1984) and collaborators described as separation-individuation is one of these stations: a critical moment in the human child's development.

Our residents belong to those people who lost the train, or else they figure it never passed near them, or that it just passes them by whenever they want to board. The fact is, that they are at a disadvantage with respect to those who took the train at the proper moment and station. Their work in the TC consists in giving them an occasion to return to the main route, and board the train, although certainly with delay.

Case Histories from the TC: Juan and Anastasia

Juan, age 21, single, communicated to us on one occasion, "In a couple of months I'm going to continue high school and I won't be able to come here any more." A little later he says that he was going to propose a meeting in order to consider how to organize the Year's End party three months from now. I pointed out to him that he had said that he wouldn't remain in our center more than two months, and that the party would take place in three months, at the time when he, supposedly, would not be there. Couldn't that be a way to avoid speaking of his announced separation of the institutional protection?

Juan showed both astonishment and fury. "So, you are going to throw me away soon" he said. "You don't want me to keep on coming here, do you?" We told him that, on one hand he wants to go, but that he also feels a strong impulse to stay with us. So he thinks - with rage - that we want to get rid of him. We considered that it would be important to examine his idea of our trying to expel him instead of thinking he is the one who wants to leave.

One day, Anastasia, age 19, single, commented in her therapy group, "I won't be coming here any more starting next week because I've got a job in a factory." She silently observed each member of the group to see their reactions. "Of course, it is not certain, but I'm sure that I'll be back in a week" she added. There was silence. She continued, "It always happens so. After working some time I get bored and they take me to the madhouse. I stay there some time and they send me again to this place."

When the day of her announced leaving arrived, she was in an ambiguous state of mind as to leave or to stay. We let her know that it is not easy for her to tell us "good bye" and that she prefers to say, "see you later." Anastasia looked at us and uttered th following as a challenge, "Why do you want to keep me back?"

These two vignettes state a rather common situation when we are working through the separation anxiety with our residents. Underlying the process is the meaning that leaving is an "expulsion" or else "a way out to the inside." A proper analysis of this facilitates the transit through the phase of separation-individuation. In the exploration of this situation we verified that the prevailing emotion is not depression but rage.

As we worked with Juan on his idea of being expelled, he remembered some situations; for example, the fact that each time he expressed a personal desire his parents said to him, "It is nonsense, a craziness." At that moment he exploded, "I was born by mistake! My parents didn't want to have more children. Therefore I always am looking for a place to be." At the time when Juan arrived in the TC, taken by his parents, he said to them, "I don't want to come here. çI'm not crazy. Why cannot I be at home with you?" During the time he stayed with us, we learned that this meant, to him, "being thrown into a rubbish basket."

Let's return to Anastasia now. Her family situation was as follows: She was the first daughter of her parents who separated when she was three. She went to live with her father's parents. Both of her parents remarried. The father's family, which had a certain social reknown took charge of her. "Her parents left her", says the grandfather. According to the grandfather, Anastasia's mother "left home to live with a man, with whom she was madly in love." The 'love story' seems to have lasted hardly three months, and that, afterwards, she become promiscuous for some time until three years before the entrance of Anastasia to the TC, when the mother remarried and had a child. The most shocking component in Anastasia when we met her was an initial attraction and contact which soon was darkened by her hostility and negativism that caused rejection in all of us. One member of our staff said, "Half an hour after listening to her I wanted to kill her, to break her into little pieces! I couldn't stand her any more!"

Anastasia defamed her mother in group therapy calling her "crazy" and a "whore", but she adopted a fascinating submissive attitude every time her other came to visit. "Anastasia seems to be another person when she's with her mother" said everybody. When the mother spoke with us she oscillated between self-justification of her behavior and a massive attack against her daughter, whom she considered responsible for her present problems with her husband and eight month old baby.

Anastasia's father came only once, coming on Anastasia's therapist's request. He said that he does everything he could for his ç daughter, but he had a new family who he also had to take care of. He welcomed Anastasia in his house whenever she wanted to visit. Their relations were cordial; everybody accepted her (Anastasia confirmed this) but soon she wanted to be the center of attention in the house, fought with her half-brothers and reproached her father for not loving her. Then she would leave, but always returned soon and repeated the same situation over and over again.

Anastasia's mother informed us that "She comes home, stays some days very well, is always fluttering around me, takes care of her brother, but she finally makes a mess, provokes my husband and I finally ask her to leave. I can't stand her any more." The mother also said that after a couple of months Anastasia returns to repeat the same situation.

At her grandparents house on her father's side, the situation was more or less the same. Anastasia insulted them constantly. She called them "softened, retrogressive elders" each time they intended to put a limit to her rambles and promiscuity. In the TC she liked to tell, in a festive tone, detail by detail, her multiple sexual adventures.

We would like to remark that any time Anastasia left home she felt rejected, by the mother, father and grandparents. The separation never had a definitive character. She always left having the intention of coming back. It was a "way out to the inside" a compulsion to repeat a sadomasochistic bond with those people who were performing parenting functions.

In Juan's case the expulsion meant an explosive dejection. As to Anastasia, it meant a return through the way out. Her speech was ç"dirty." Soon after her announcement of leaving she said, "So you throw me away as if I was shit." So she returned to the TC in the form of a fecal penis to disorganize the group and the TC. She became explosive, manic, maddening to the extent that her absences were felt with a great alleviation by the other residents.

Anality and Domination: Its Relation with Narcissism

In order to articulate the clinical experience with psychoanalytic theory, we may say that the expulsion is bound with oral (to spit) and anal (violent dejection, flatus) sadism. Melanie Klein would say that it relates to an envious attack on the pregnant mother or parental couple made with excrement and flatulence. This attack bears, on one hand, the pleasure of the discharge, and, on the other hand, the fear of having this aggression turned against oneself.

Juan, before his leaving, remarked that he nowhere else received all the attention that was offered to him in the TC, but for a while the institution was no longer useful for him. The food was "nasty", the people were "dirty", and it was as easy as leaving a trash basket. Separating from the institution was how Juan recovered his own value. If a child gives to his mother what she appreciates (excrement), the child will be appreciated by the mother. Merged into his mother's desire, Juan tries to recover his self-respect; he isn't any more a "nastiness." But this is a destructive union, where value makes room for a mutual "burst." His drama is then to "be someone special, a genius (megalomaniac phase) or else to "be nothing, nobody." His anxiety due to the impossibility of "being someone" separated from his mother, without blowing her up or himself, was evident at the moment when his mother was going to be operated on when he said, "What is çgoing to happen with me if my mother dies, she's all that I have!" It is clear that he had others family members to take care of him: father, brothers and his older sister.

Starting from sphincter control, the child's increasing dominion over his body and its functions configures his feeling of self, the consciousness of his own abilities, his own self-respect and self-appreciation, which are the nucleus of the "narcissistic sector of the psyche."

It is in this moment of psychological development when "anality", through the domination impulse, becomes a structural part of the personality. In Three Essays on Sexual Theory, Freud (1905), said that it is "not originally a sexual impulse, and, that it only secondarily can join the sexual impulse" in order to explain

"the infantile cruelty that seems not to take into account the other's suffering." It deals with the human being's tendency to master something. It's an impulse in the service of self-affirmation and growth. The domination impulse is the implement that the ego uses to transform the archaic infantile narcissism into a mature product regulated by the reality principle.

The relationship of the child with his bodily products, and through them, with his mother, is a narcissistic relationship. A disproportionate rejection of the child's bodily products frustrates the child, adversely affecting his self-respect, e.g. "You are a shit" or "All that you do is shit." If the child's bodily products are libidinally invested by the significant adults in the environment, this increases the self-respect, the internal cohesion, the self-identity, and opens the way for the sublimation of this archaic and narcissistic domination impulse.

Rage: The Predominant Emotion

We saw that both Juan and Anastasia got angry when they considered leaving the TC. Leaving was experienced as a narcissistic wound, a projection of their own unappreciation of the therapist staff. The frustration, proper to the psychological developmental phase, of their narcissistic need of being loved and appreciated by the object (the therapists as parental figures) forced them to develop a chronic rage. This way they became hypersensitive to any therapist's slight which was experienced as a personal rejection. Heinz Kohut (1978) states on this subject, "The mere fact that the other person is independent or different is experienced as offensive by those with intense narcissistic needs."

Based on our clinical material we are able to affirm that "narcissistic rage" emerges as a dominant emotion when the subject feels frustrated in his domination impulse. If his is a child this occurs any time when his infantile omnipotence is attacked. If his is an adult who has reached certain transformation of the archaic impulse, this occurs any time he feels he is losing control over situations where he felt self-confident.

The narcissistic fury is a distintegrative regressive product of the mature and self-affirmative aggression in a clinically healthy person. It appears like the available answer in those who are vulnerable when receiving personal censure since they need an external support to feel worthy and alive.

Conclusions

Our examples regarding leaving the TC served us to articulate the çclinical experience with the theoretical explanations of it according to psychoanalytic concepts. This way we examined the role played by the anal period of development, with its domination impulse, in the constitution of the narcissistic sector of the psyche and during the separation-individuation process. When this process is altered by diverse circumstances, the predominant emotion is rage.

Juan felt himself to be a "nastiness" expelled by his mother during childbirth, as an expression of her unconscious desire to get rid of him. His leaving from the TC regressively mobilized an archaic situation accompanied by an intense disorganizing rage. As for Anastasia, she seemed to re-create a proto-fantasy, which Freud called "intra-uterine life." Birth, followed by separation and progressive autonomy meant an "expulsion from paradise." To emerge from the womb meant losing the "oceanic feeling" and pleasure of symbiotic union. The movement of "way out to the inside" is an expression of this situation.

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THE ROLE OF ART AS A THERAPEUTIC TOOL

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I would like to explain to you what we are going to attempt to do with this "art" program. More important is for you to understand what we are not trying to do, and you will see how the two extremes will hopefully meet in the middle and accomplish what now seems abstract or foreign to the people participating and become a visual reality. When we talk about art we tend to think of a beautifully realistic painting, aesthetically pleasing to the eye and, uncomplicated, easy to understand, i.e., a painting, trees, flowers, houses, water, things we look at and see all the time. Familiar things. We are going to use the tools of different art forms to put into visual works those feelings we all have inside of us. The ones we don't have pictures for, or even words. Nevertheless, they are there. The famous artist of the 40's - 50's, Jackson Pollack, was a very sensitive, highly introspective man. He had many feelings that he needed a release for. His canvasses were always stretched out on the floor so that he could get down close to his work and feel he was a part of it. He proceeded to splash out, drip, push paint all over the canvas. When Pollack was upset, or feeling sad or feeling good, he would go into his studio, put those feelings, the ones he nor anyone else could reach, and put them down on canvas in his own special way. His works, a product of his feelings. No one can copy a Jackson Pollack. We are going to attempt to reach those feelings, the ones that make each of us, different from the guy next door. Kids coming into this program may seem a bit baffled at first. But once they begin to understand that they aren't expected to become "painters", but to use the medium as a form of showing their feelings they will see that color can be representative of feelings, also shape and the use of clay, collage materials, etc. A very useful tool to be able to have available.

A young boy flipped out from dust. He went into a program, but spent many months unable to be reached. He was arrogant, refused to socialize or talk with therapists. But he spent a lot of time "making things". He made an ashtray out of clay, a very deep one. Out of the center came the pieces that would hold a cigarette, long necked, round on top, staggering, leaning, different sizes, painted black. A kind of chaotic looking piece. One day his doctor saw it and asked him what it was. "Just an ashtray I made" was the boy's reply. The doctor said it looked like more than just an ashtray to her and that all things one makes have a meaning. Together they retraced the steps leading up to the day the boy made the ashtray. They found that it had been a very frustrating, confusing, painful day for him. It was the first day his parents and brother and sister came to visit him and his family did not handle it well, Nor did he. It's easy to see that all the pieces coming up in different directions leaning, some lower, some higher, were representative of the boy's family. The black ashtray was telling the story what the boy felt and saw and experienced that day, the feelings he couldn't tell anyone about, but without even knowing it, became crystal clear in "just an ashtray". The boy began to open up and talk about his family, eventually completing the program. It isn't "the" answer, but it is a helping hand, a different kind, but one to definitely be considered and included in a host of therapeutic tools.

TOWARDS AN ETHICS OF THE TC MODEL IN THE APPROACH TO THE ADDICTED PATIENT

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"I am a Man, I consider no other man a stranger.".
–Miguel de Unamuno

In this paper I will consider those aspects that account for the characteristics of the ethics of the TC model in the approach to the addicted patient, without entering into an analysis of the pathological features of the personality of these patients, nor abounding in explanations on specific working techniques in the TC.

I point out that, in the exploration of the structure latent in the human condition, I think of scientific work as a dialectical search between the territory still unknown, and its contrast with human reality, as a presence and a convoking power, in our daily effort. I am aware of the fact that "as different beliefs are not always explicit and expressed, he who thinks and creates on the basis of such beliefs, makes them apparent in the context of the system where they articulate with each other" (1).

The TC has a goal that is common to its members and a specific organization which operates as a whole towards the objective of combi- ning mechanisms which will allow it to perform its corrective and structuring task. Personality and social dysfunctions treated within it may be varied, though in this paper we emphasize the assistance given to patients whose principal symtomatology is drug abuse.

What do we understand by personality and social dysfunctions?

By this term we define those particular forms of psychic organization that promote a special manner of social integration, which induces the diseased person to sink in the "alienated pole" of the society he belongs to.

Thus the diseased person, trapped by a number of forces he does not know, suffers an identity disturbance but, also, he is socially condemned to not-identity as a person. He is sunk in contempt and indifference, and thus he begins his progress towards an irrecoverable condition, due to the chronicity his self is tied down to.

Some of these forces unknown to him are the actions supported by a social system that promotes certain cultural models for personal relationships.

The forms of submission of man to man, of man to the economy and the state, of countries among themselves, and the exploitation of nature by man, promote alienated and destructive relationships. These relations are supported by certain models of progress and development which, for instance, are based on particular production-consumption patterns and on the progressive concentration of political and economic power.

From this environment the addict emerges and, under a permanent compulsion towards self-destruction, he may end by being the repository of a set of contradictions which exceed him and which he expresses, before the external observer, as an objectification of the accusation implied in his existence.

We are conscious that we belong to an ailing society and we intend to promote other values supporting the promotion of the human being.

We know that, when assisting an addict, we are only treating the consequences of a problem which exceeds him largely and which encompasses us too. That is the reason why we have answers for the individual pathology, but many questions posed by the social problem denoted by the pathology still remain unsolved.

Therefore, our task should have a double purpose: to treat the diseased person and to work towards social health, that is, in the prevention and for the suppression of the conditioning causes of this epidemic of drug addiction.

We should not feel the addict as a stranger; we are accomplices of his same condition, in the sense that we are involved, essentially, in the same constitutive factors, even though we have been endowed with a different personality organization and an identity of a different quality, which gives us other capabilities of relationship and exchange with the surrounding world.

In agreement with this general presentation of the problem, we can consider the features that distinguish the ethical model promoted by the TC in the treatment of drug abusing people.

I will develop three themes:

1) The general principles that should rule the community organization.

2) The notion of therapeutic role.

3) The model of approach to the addict.

1) General principles that should rule the organization: the institution organized as a TC offers a restructuring social framework for the addict's personality. There are three basic principles for this transforming process to develop, namely:

a) The authority principle: one of the more consistent phenomena which account for the addict's anomy, are the serious failures in the paternal function within the familial structure from which he has emerged. This generates in him a deficient identification, absence of limits, confusion and fear regarding the surrounding reality, disorders in the handling of aggression and perversion of the vital values guiding his own actions. The addict requests, in multiple ways which must be understood, the reinstatement of this paternal function, so that it will allow him to halt his advance towards self-destruction and make possible a new organization of his internal world.

The TC, aware of this problem, grounds its structure in an authority principle based on love, respect and the guidance of its members towards independence of judgment; towards the achievement of a free self-determination, understanding freedom as active responsibility. The realization of this principle generates the establishment of a series of rules which organize the activity of the whole. These rules must be explicit and must involve a permanent analysis of people's actions with respect to them.

b) The principle of institutional environment: the authority model and the establishment of rules to govern the organization generate a model of environment for institutional work. This environment must always be an object of study and improvement, so that it may generate increasingly sympathetic bonds among the members of the TC .

"In this sense, the important thing is to understand that the rule must be observed and preserved, no matter which rule it is; that its infringement implies a consequence, and that this theoretical relation between the rule, its transgression and the immediate consequence operates, in practice, with equal smoothness" (2).

This will tend to promote, in members, a self-criticism that will compare the manner of satisfaction of the individual need and the needs and welfare of the whole. This promotion of a sympathetic attitude faces the addict with his fantasies of "individual liberation", with which he permanently tries to disguise his tragedy.

The series of rules which express the model of working environment has double purpose: that of guiding the institutional therapeutic function, and of being useful for the content analysis of the permanent "acting-outs" generated by the addict.

Any unexplicit aspect of the environment will generate confusion and will create a space apt for the development of serious institutional conflicts, the solution to which will imply a high cost in terms of time and effort on the part of community members.

"The environment is a goal to be achieved, which must be introduced so that the therapeutic process may develop. The environment represents the discriminating limit between reality and imagination" (3). And if we think, as Freud, that "... the new external fantastic world of psychoses wants to take the place of external reality" (4), we must understand that it is the environment model that makes possible our way of observation, analysis and modification of the patient's internal reality.

c) The principle of belonging to the organization: this principle is observed in the sense that one must be permanently aware of being a part of a structure.

From the point of view of the TC concept, the Institution is the basis for the members' activity, and each therapeutic activity acquires its meaning in relation to the whole.

Individualistic attitudes, such as solitary actions by sectarian subgroups, for instance, damage the sense of organic action of the Community, and must be analyzed as deviations that impair the therapeutic function that it must perform.

It is an actual fact that mental health establishments that do not carry out a systematic evaluation of their own performance tend to reproduce, within themselves, those pathological mechanisms that they purport to cure in their patients.

This is an institutional identification with the object of their work, of which we can briefly mention the following examples: the split in and isolation of different working teams, the dissociation of therapeutic and non-therapeutic activities, the absence of a responsible authority or the authoritarianism that promotes pathological rivalries ending in the generation of "acting-outs" by members of the staff, schizoidism in the transmission of information, the denial of conflicts existing in the institution, all of which produce a distorted view of the organizational reality.

The notion of therapeutic role: the community model enriches the traditional model of individual analysis. The patient is the active subject of his own treatment, within an organization designed to understand him, to help him change and in which he is respected as a person. Thus, in his daily behavior, he will show his capabilities and difficulties, increasing his possibility of insight, due to the multiple approaches to his behavior patterns that will be accomplished in the course of the different activities of the therapeutic program. He will be observed in his interaction when working in different groups, or when playing, eating or sleeping; his leadership style, his relationship with the organization and its rules, his behavior in critical situations and under which circumstances these arise, how he solves his gratification needs, etc., will also be noticed.

While he acquires a new dimension of himself and his disease, the patient will go through a learning process of reconnection with the world, in which he will be an active participant, and not a passive recipient of a treatment provided from the outside.

In this sense, the concept of therapeutic role acquires a greater dimension, as this function is not limited to the professional staff. It includes the capacity of any person to establish a vital bond that may be useful to understand a conflictive situation, to be a "mirror" for another's pathological behavior, to offer help and to preserve and improve the operation of the institution. On this same line, we believe that psychotherapeutic activities are nobody's private property, though different degrees of responsibility and expectations may exist, according to the position held within the formal organization.

All members of the administrative, professional and services staff must be trained, therefore, in a double sense: in their specific tasks and in the importance of their role in the institutions's operation, in the reasons and objectives of the different organizational modes of the TC.

No labor function may remain isolated from the community life, for an institution is nearer to becoming a TC when it develops in its members a state of permanent awareness of the goals it wishes to achieve.

For this reason the therapeutic role may be played by the patients themselves, and this is encouraged. Thus they are globally incorporated into the general activity, and they find it possible to adopt an attitude, inherent in the human condition, which allows them to perform coordinated actions of remedial effects for themselves and others.

The model of approach to the addict: Even though in previous sections the features of this mode of approach are suggested, I wish to make somewhat more explicit the vital point where the TC places itself to try to rescue the patient from the loneliness in which he denies and is a product of the isolation in which he finds himself. "... the addict confines himself to his toxic loneliness and confers his deprivation the dignity of a miracle plenty of meaning." (5)

The TC intends to move him by presenting the meeting with the other as one of the foundations of its therapy. This meeting is at the same time a discovery, insofar as the addict, from the narcissistic structure of his personality, denies the presence of the "other".

In this process, the addict finds that the "other" (person, group, institution) has a series of ideas regarding his or her self, body, sexuality, life and death. He discovers that the addiction develops due to the conflicts originated by those same problems, the addiction in which he dissolves his existence, in a magic, omnipotent attempt to face such problems by means of the idealized and destructive bond with the pseudo-object drug. Thus, he will find later that this pseudo-object is a carrier of death, which he had denied in his omnipotence and returns, sinisterly, under the guise of "pleasure", life or "paradise".

In this sense, the TC promotes the effort of constituting, in the first place, this duality, novel and regenerating for the addict. And while this "I-other" pair, determinant of a new structure, is developed, one enters progressively into the personifying stage of "we". We, working together in order to improve the quality of our life and building, a socially meaningful reference point becoming a new focus for organizing one's life.

Thus, we note that the addicted patient finds, in the TC, a different world of relationships that impress him and surprise him, because they place him in a different condition. They drive him out of his dependent and self destructive world, and engage him in a structure that, gives him some psyche on his own existence.

In this new alternative the possibility lies of encounter with life, with love, with rules and the model of identity which will provide the capacity of active and creative integration into reality.

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A REHABILITATION PROGRAM IN BRAZIL

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When morning prayer comes to an end, sixty Brazilian youths in a group exchange handshakes, a pat on the shoulder, sing a hymn, and then wander off to their work assignments. Ask me: start of a day in a seminary? In a young peoples' retreat? No. It's the beginning of the day in a live-in drug-alcohol rehabilitation center on a ranch in Campinas, Brazil, and prayer is the first exercise of the day.

I founded this center six years ago; but as Padre Haroldo, the only name I'm known by in Brazil, and I am a twenty-one year veteran missionary there. I hail from the New Orleans Jesuit province and I was among some of the first missionaries to leave the United States when Pope John XXIII called for reinforcement from North America for the Church in Latin America.

The center is located on a fifty acre farm about twelve miles outside the city. There, with the assistance of a dedicated and qualified staff, I guide my young people through a nine month recovery and re-motivation program. In Brazilian, the official name of the center is *Fazenda do Senhor Jesus*. The English equivalent is *Ranch of the Lord Jesus*.

I really began my first work with problem youth - delinquents, alcoholics and prostitutes - way back in my seminary days. Then, in the 50's, to counter the rampaging gangs of the El Paso ghetto areas, I founded Our Lady's Youth Center. Today, it still provides sports ç and other recreational activities for young people. Some fifteen years after that El Paso foundation, in the distant southern hemisphere, I started the Kennedy Social Center, a trade school - so to speak - on the south side of Campinas, Brazil. That too, remains in existence today. Shortly after that, together with a Brazilian group of Good Shepherd Nuns, I opened a residence for babies born of mothers of the red-light zone. But when I saw the terrible toll in broken marriages and anguished homes caused by drinking and drugs, I decided to apply the best remedy I knew: provide a family environment for the addicted.

I began with a dream, a donor and grit.

I had the dream and I sold it to Mr. Claudio Novaes who bought property and building material for the project.

The property was set in an ideal location: a rolling countryside overlooking a narrow river provided the peace and serenity needed for healing. And its isolation at the end of a long dirt road kept the problems and distractions of city-life far enough away from us. A couple of bungalows on the land housed workmen and a handful of volunteers. Within a short time the largest of the structures was modified to lodge 12. We built a small but functional kitchen and dining area and a type of hall or large room which served as prayer-area, recreation hall, group meeting hall and a multitude of other purposes. Along the front of this same house, we built a wide veranda which over-looked all of our property and the river for as far as the eye could see. This first house has been re-modeled and re-modeled to keep up with our needs and even now it is undergoing enlargement and refurbishment.

So we had the dreaur farm produce. Our herd of cattle was increased through a donation from the Brazilian Jesuit province, and a Jesuit high school in Tampa, Florida, raised money for us to but a tractor.

Within a year we were over-crowded due to the number of applicants. By 1981 our ranch accommodation grew to three times its original size and we had 50 residents. With this growth other changes naturally occurred: we built a soccer field, a laundry, a carpentry shop and a garage for farm equipment. ur farm produce. Our herd of cattle was increased through a donation from the Brazilian Jesuit province, and a Jesuit high school in Tampa, Florida, raised money for us to but a tractor.

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I think that the success of this ranch rehabilitation center is naturally due to its demanding need and to its unique structure. When I began, I really never gave much thought to my methodology. All I wanted was something simple and workable. And did it ever work! We can't keep up with the applications. The waiting list is endless. And they do wait; simply because they want to come.

Jorge, 43, came to us totally dependent on alcohol. He had already hit "the bottom of the barrel." He had been a man completely lacking in self-confidence and couldn't relate to other people until he discovered the bottle. He told me, After downing a few shots, I felt different. The barriers fell and I was at ease in conversation. But unfortunately, I didn't stop there and people began to treat me like I was garbage. In your program, people treat me like a human being. You and your staff made me believe in myself."

The stories go on and on.....Tadue, 21, came from a broken family and was so totally hung up on drugs that, as he explains, "It was an escape from what I thought was the drudgery of survival, of complete emptiness. I wanted to kill the torment, so I just drugged myself. I lived like a man already dead, a human vegetable. After nine months in this program, I feel like a new person with a free life, a real human being. I'm really happy. I feel ready to study, to work, and to live like normal people do. And God's become very important to me. From time to time depression still hits me. I know that I just couldn't stand it without him. He makes me strong when I'm weak."

The structure of my program - or really what it has gradually evolved into - involves a thorough approach to the addiction problem and tinges every area of life of the total person: intellectual, volitional, affective, and social, because the human person doesn't live for himself. He must live for and with others. So besides re-educating the person him/herself, we assist them in the crucial problem of returning to society and accepting this or her obligations in very dimension of life.

The daily prayer is an indication that the spiritual dimension is central. Though the program does nor force adherence to any particular church, it does demand that the rehabilitants confront their religious needs. Each one must take part in the spiritual activities like morning prayer and other moments of spiritual çonfrontation during the day. I believe that in every person there is something that calls out for God and wants to relate to him. So, I lead my rehabilitants in prayers that express belief in God, in his mercy. I try to reinforce in them the idea that we need to put ourselves at his disposal, concentrating on the power of his grace. We use the Bible and popular Brazilian Christian hymns. Hope for healing - any healing - comes from working on this spiritual dimension.

Secondly, I believe that the human spirit is an embodied one. Hence, our program stresses physical exercises of every type: body-mind coordination and relaxation, physical and occupational therapy, sports, and the constructive use of leisure time. I like to lead the residents in certain forms of Oriental prayer that integrate bodily activity with the inner life of the spirit.

As I see it, the two main forces for the type of healing we are seeking our spiritual and physical. These forces live within every human being. All that we must do is take the time and the effort to bring them to the surface and then utilize them to the fullest extent.

For this reason, my staff - an interdisciplinary one - is of vital importance to me. They are the ones who collaborate with me, according to their various capacities, to integrate the entire program and set into motion in each rehabilitant the forces below the surface. I work in the program in a general way as director and coordinator. The task of the staff is to meet the needs of each rehabililitant on a one-to-one basis and resolve individual problems and begin the re-structuring process and see that it is carried through to the end.

We have professionals and para-professionals all working toward the same goals. They include psychologists, social workers, ç educators, occupational therapists and ex-rehabilitants who have opted to remain with us because they have gone through the program, have first-hand experience, and as I see it, are in this sense among the most valuable staff members. Their perspective of rehabilitation is perhaps different than ours and they have the capacity to relate to our clients in a manner that no other staff member can.

With regard to our program structure, we conduct screening interviews, oversee testing, and run counseling and group sessions. We also offer courses leading to marketable skills that will later be useful in job placement services.

I also place great importance on the interaction of rehabilitants themselves. The new person who is emerging into a new way of life is living in a community of other persons who accept him as one who like themselves, is struggling and changing to become a new person. This mutual assistance is crucial to the program, and call it by any name your like, I see it as a sort of family structure that lends support and understanding at every turn in the road to sobriety. This is serenity in action: the ability to help and to let oneself be helped with humility and acceptance.

We do more than just pick troubled people off the streets.

We operate an intake center and detoxification program that lasts one month. Most of our clients come from the poorer classes and cannot afford to pay for services. So we've turned into a self- supporting operation. We sell our farm and dairy products and woodwork and other objects than come out of our carpentry shop and arts and crafts classes. But this is not sufficient. We seek donations from public and private sectors and from foundations both in Brazil and abroad.

We offer courses in various cities of Brazil for the average working person. These courses are based on the same type of spirituality we offer to our rehabilitants and we have met with great success. The donations from these courses are directed toward maintaining our rehabilitants through their nine-month program.

Our rate of cure for those who remain for the full-term is fifty percent, looking at it from an overall basis. It may be higher; but I prefer calculating it as realistically as possible.

I'm always open to new trends and ideas and new ways of meeting both old and new problems. Let me give you an example of how we must continually adapt our methodology and system. When I first began my work in this area, my program attracted men averaging thirty years of age and mostly addicted to alcohol and marijuana. Recently, there has been a drastic shift in both age and addiction, and we've had to shift our gears to meet the change. Our Intake Center reports an upsurge in high school drop-outs all under twenty-one years of age, and for the most part addicted to cocaine and amphetamines. This creates the need for new patterns of rehabilitation because the risk of long-term psychological dependency with these users is much higher than the persons we've dealt with in the past.

We've also entered the prevention arena. Communications is the name of the game in prevention: make both young people and their families aware of the problems, the risks, the effects, the means, the services. We began on one TV channel, once a week, in one city. Now channels in other cities are requesting programs and more than once a week. This new area of our work is exhausting and time-consuming but the audience is large and the feedback positive. We are hitting at ç least some of the people in some of the cities in Brazil. People I'm trying really hard to get to back me up are those who influence the young: artists, especially singers, entertainers, teachers, coaches, etc. We've got to hit these people and it them hard. They influence public opinion and are the idols of our young people. They set the trend and the others follow.

Another important area of both preventive and curative measures is the family. We plan to open family counseling service centers that will serve the families of young users. We will not close our doors to families with older dependents, but we see the real need for hard core work and services for parents of chemically dependent children who have not yet even reached high school age.

Just as I began my program with a dream, each person carries a dream and vision of life deep within him/herself. Unfortunately, that dream, for the chemically-dependent person has turned into a nightmare. My prayer, my work, my undying dream, is to help these persons once more turn their dream of a beautiful and fulfilling life into a reality. If I can do this for at least half of the people that I serve, then I know that my own dream has been realized.

REFLECTIONS ON GRADIVA TC IN ARGENTINA

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If we think as Martin Heidegger, that every word is related to an original experience, to a significant space, we should wonder about the meaning of the word Gradiva, which in itself leads to a therapeutic plan.

In this case the word comes into being not only as a fossil past, but as a potential drive towards the future. Gradiva acknowledges Freud's works as its foundation. But, which Freud? That one who teaches us that it is within language that the problematic horizon of the symptom must be deciphered A language that is the language of the family, the story of the family, and the story of the individual. A language that shows a social crisis through a symptom. The Freud that recalls in nostalgia the poets as the ones to understand the multiple sense of words and reality. The Freud who speaks of the linguistic meaning of the symptom; that appeals to feeling, to love, what Freud calls "the cure through love."

In 1972, we proposed to listen to the patients. We broke with the social conventions about madness. This was not a passive listening to the patients but active search that had to start from looking within oneself.

At this point, we realized that the institutional structure is important in producing change. The community should be a place to encourage questioning, to generate communication. To achieve this, we followed Maxwell Jones' theory of the therapeutic community, adapting it to our way of life. The democratic participation, emphasized by Mr. Jones, implies the possibility of setting language into action, which can eventually bring about growth in the patient because it allows him to symbolize. Language ought not be used for social control or in subjugating th patient. The different groups in the TC lead to resocialization. A language will develop that will recapture the story of the individual and the family. Through this conception, the TC as defined as a symbolic organism, not only a corrective process to bring about behavior change.

We take Pinel, Freud and Maxwell Jones' theory as the foundation for investigation in psychiatry, psychoanalysis and social psychiatry. Psychiatry frees the patient from chains, psychoanalysis releases the patient from guilt, and social psychiatry based on Jones' concepts of the TC, demonstrates the relationship between society and madness. These three discoveries described as psychiatric revolutions, have been extremely influential in psychiatric practice, but have not had much influence in psychiatric institutions. Gradiva has tried to provide an alternative to this paradox.

Family therapy, the fourth psychiatric revolution, will be frustrated if we do not change the majority of institutions which primarily articulate techniques of social control and subjugation.

For these reasons, a linguistic approach is important to set all the actors to confront the word. This acquires important characteristics if we understand what the word addiction means.

Addiction comes from the word adictum which means slavery. The addict does not speak. As he is not able to speak, he becomes a slave. He is marginal in the symbolic sense. Not being able to speak, the addict remains locked up in the quietude of non-action. The TC offers the support for the addict to speak, for the family to speak, for society to speak. The symptom of drug addiction is a caricature of what is called a healthy way of life. The technocratic society is generating addicts very fast in the same way that traditional society generated hysterias and obsessional neuroses in the big ballrooms of Vienna during the time of Freud.

What is remarkable in the family, is the "decay" of the father's image, a father who is absent or, if present, is overly narcissistic. He appears in the family histories of our patients as dead, missing, humiliated, denigrated, consumed in our consumer culture; the border-line father who is resentful, violent and a thief, distanced from what is shown to him as desirable to attain, but which he can only sparingly get.

We live in a suicidal civilization from which the addict is the perfect exponent. There are over 50 million addicts in the world, some addicted to alcohol, others to drugs and psychoactive chemicals. The slow suicide of the addict is the most evident example of what Freud in his work, The Ego and the Superego showed as a culture of destructive instincts. The ego ideal is no longer the producer of sublimations that are expressed in art and religion. It is the superego which submerges the human being in the tyranny of death.

We live in a society which has buried the great ethical systems and promotes the blind ethics of the marketplace. Through this our young people are converted into the merchandise of big business.

I believe that addiction, being a psychosocial pathology, needs institutional support to promote the symbolization of conflicts. The TC's main task is to interpret the addict's language and move toward rehabilitation. Healthy family systems need to be developed, and TC's must work with the family. The TC must promote health through play, where the creative act is associated with vital spontaneity. I think that human problems are the result of some deficit in the development of the child, in the lack of creativity when the child has no motivation to play.

Reaffirming the need of a space to play in a communitarian group implies a criticism of the automated, too serious and monotonous way of life that forgets about the feeling of happiness in being alive.

The TC needs to encourage health by encouraging its members to work inside and outside of the program, because man can discover the possibility of transformation while he performs meaningful work. The TC must promote health as a subject of discussion in every situation, including the school, the church, the university and the neighborhood. This service is needed in the community and the community will change for the better through this service.

THE THERAPEUTIC COMMUNITIES OF THE SOPIMUSVUORI SOCIETY

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The foundation of Sopimusvuori has been described elsewhere (Ojanen, 1984). Here I describe the development of Sopimsuvuori through those crises and challenges which have been met during its working history.

CHALLENGE 1: Swelling Mental Hospitals

The mental health district of Pohjois-Hame (in and around the city of Tampere) had during the 1960's a population of 300,000 and the number of mental hospital beds was over 1300 (about 4.5 per 1000). Mental health clinics existed, but a major alternative for practically all kinds of trouble, be it senility, alcoholism, or any kind of odd behavior, was the mental hospital.

The district director saw all this all right, but could not do very much because of custodial attitudes and old mental health laws. He initiated a home-care project, however, and wanted to show that patients could be taken care of in their homes, if properly supported. This study was a success in many ways, but it was not put into practice extensively.

OUTCOME: The home-care research group saw that there was a lot of rehabilitative potential in hospital patients, but very much could not be done in the existing mental health organization. Seeing this, one of the home -care project workers, Leena Salmijarvi (RN in psychiatry) ç wanted to do something and arranged an apartment for six women patients who all had been at least 10 years in mental hospitals. The district director supported her in this experiment.

CHALLENGE 2: Helplessness of Patients

The condition of the patients was very poor. They were released with great doubts and told, "You cam always come back to the hospital where your proper place is."

OUTCOME: Though the patients did not much oppose the move into an apartment, they were quite helpless at firs. They were poorly equipped for every-day living, and they could not use the bus, telephone, shops, etc. Leena Salmijarvi (hereafter known as L.S.) had to help them daily. She stubbornly showed them how to make food, and how to manage practical matters. After a difficult start the women began to blossom. They really enjoyed their new life and took things energetically into their own hands.

CHALLENGE 3: Losing the Apartment

The owner of the apartment died and the women lost their apartment. At first it was a great shock, and when the hospital could not give them any living quarters outside the hospital, this brave experiment seemed to have come to an end. The women had to back to the hospital.

OUTCOME: The women did not agree with this verdict. They acquired homes for themselves independently, because they did not want to go back to the hospital. Since then, no one (except one for a very short period) has come back to the mental hospital.

CHALLENGE 4: Looking for New Chances

Courage among those people who had participated in the experiments increased. But what could be done? L.S. saw a newspaper advertisement, where the upstairs premises of an old people's home was available for renting (because of new safety regulations it could not be used any longer for the care of old people).

OUTCOME: Six new patients moved into this place. Officially they were in home care under the responsibility of the director, because this had been the only way to release them from the hospital. The treatment of patients was in many ways similar to the care of old people, who still occupied the downstairs rooms.

CHALLENGE 5: Continuity of Work

The old people's home was ultimately closed and the whole place was offered for renting. The patients had been there for two years and they still needed care. Now it was crystal clear that there were many similar patients in hospitals waiting to get out. Many were in a fairly good condition, but had no place to go. Mental hospitals could not support this kind of activity.

OUTCOME: L.S. wanted to continue the work and got support from any persons. When no other ways seemed available, it was decided to found a Society for placing patients outside mental hospitals. L.S. personally with her friend promised to pay the rent for the first three months. The society was founded in 1970.

CHALLENGE 7: Shortage of Money

In the early years even sustaining the first hostels seemed impossible. However, L.S. and others had definite ideas about developing Sopimusvuori. New hostels, a workshop, a day-center were on the list.

OUTCOME: The founding members had to resort to their wallets and personally guarantee bank loans. Voluntary work was started and with it "the spirit of Sopimusvuori" came about and has stayed since. New places, in addition to the above, were founded without knowing who would be paying for them. Of course, everything was done as inexpensively as possible. All premises were old and often in poor condition. The first job was to do some renovation work at these premises. Here patients and volunteers were often of great help.

CHALLENGE 8: Philosophy and Working Methods

It was not obvious how the various places should function, though L.S. had visited Great Britain and was familiar with the ideas of the therapeutic community as designed by Maxwell Jones. She is very practical minded and does not put her fingers in her mouth when a crisis is at hand. She had a direct way of doing things and this was also a model for others. But was it enough? There was not much training or discussions about ideology or work-methods. There was too much to do all the time. New workers were supposed to know what to do and mostly they did. However, ideas of therapeutic community did affect the workers of Sopimusvuori. What is it and how should it be applied? On the other hand, there were pressures to make it good for patients, to compensate for their sufferings. The hotels should be some kind of convalescent homes, where the clients can just enjoy their life. In many places the clients accepted the services where they got it and protested if they were required to do something for themselves. In the free and warm atmosphere of the hostels and day- centers they were often very passive and took no responsibility.

OUTCOME: Just plain common sense told us that the full-service idea could not continue. some of the communities had already started to cajole clients to participate and to work and others followed them. Participation was now required as a matter of fact. This change did not result from any theory, but from experience. Many of the workers were laymen and did not know much about schools of psychotherapy. However, at the same time, the principles of therapeutic community were more openly discussed. Most, perhaps all, of the workers believed in these principles. They wanted the communities to be democratic, equal, open and warm. Some felt that a good atmosphere brings out the best in the clients. This did not work out too well, as was told above.

There has been a continuous dilemma in some communities. Where do you draw the line between democracy and authority? Some of the workers believe very strongly in democracy, responsibility and tolerance. It seems that both their profits and their losses have been greatest. Somewhat later the staff was familiarized with the concepts of social learning and most of them have taken courses in transactional analysis. The training of social skills approach has been easy to adopt because it fits well with the practical attitude. It is a general feeling among the workers that theories are not very helpful in everyday work.

CHALLENGE 9: Hostels Make Clients Passive

In about four or five years it was clear that the hostels, though they were small (10-20 beds), did not work properly. clients stayed the whole day alone in their rooms and ate what and when they pleased. Many did not car about their appearance or the environment. There was no group-feeling among the clients. Though the hostels were supposed to be only temporary living places, there was not very much movement to private or community housing.

OUTCOME: In a few years hostels were abolished. Instead small homes were founded. Clients moved into these Rehabilitation Homes (RH's) from the hostels, and as a first step in Sopimusvuori. The RH's are for 8-16 people and each RH has a staff of 1-3. In most RH's the daytime is highly structured consisting of home-care, making food, various groups, etc. Similar ideas are applied in small homes in which there are no daily workers.

CHALLENGE 10: Response of the Community

The reactions of nearby people have been quite variable. Especially the second RH had conflicts with the people who were living in the same building. The passive clients made no noise or harm, but their presence was too much for some. This RH moved into another place. Also, it was difficult to get enough apartments for clients in order to get them out of the Sopimusvuori.

OUTCOME: The above example was actually the only one. Sopimusvuori has tried to be very open in many ways. Anybody can visit the communities. Gradually Sopimsuvuori has acquired many friends and volunteers. There is now no shortage of apartments. Each week more apartments are being made available to Sopimusvuori.

CHALLENGE 11: Visitors

Sopimusvuori had some visitors in the first working years, but from 1975 onwards there has been an increasing trend in the amount of visitors. First the staff and especially the clients protested about it. Visitors clearly invaded their privacy. Many clients simply vanished when visitors came.

OUTCOME: Visitors could not be turned away, especially not when they came from mental hospitals and foreign countries. Soon clients started to adapt to the flux of visitors and noticed that they were living in a special place. They were also given a more active role in showing the places and telling about them. They could also earn extra money by making food for visitors.

CHALLENGE 12: Staff Independence and Responsibility

During the first years the staff complained often that they were given too much responsibility. in hospitals you can consult in difficult matters or can give the responsibility to others. The staff also wanted clear advice as to how to treat the clients. What are the objectives of the various places? When should a disturbing client be taken back to the hospital?

OUTCOME: The critique was often justified. Nobody knew what was coming. The staff simply had to take the responsibility for their communities. They had practically free hands. Training was increased and each community was given a counselor with whom they met weekly or twice a month. The problems solved themselves when the experience increased and autonomy became a way of life.

CHALLENGE 13: Integration with Hospitals

We are now coming full cycle. The first challenge was the swelling hospitals. Though the number of beds has decreased to 32.9 per 1000, the effect of Sopimusvuori has not been as great as it could be. It is still a private association, obviously very useful to the district, but it is not fully integrated with other mental health services. There has been, now and then, empty beds in Sopimusvuori, because "there are no suitable patients to send." The rehabilitative steps have not been clear enough. The closing of mental hospital beds is opposed by city officials, because they want to use them for the care of old people.

OUTCOME: We are looking forward quite optimistically. The present director works for an integrated, stepwise system and believes that part of the hospital beds could be closed. A large research project has been developed in order to find new solutions and ways of treatment and rehabilitation.

RESEARCH RESULTS

Follow-up studies were started in 1971 and after this many studies have been made (Ojanen, 1984). Here I list some generalizations based on the research.

1. A typical client has a diagnosis of schizophrenia, is single and has been at least for one year in the hospital. The first clients had been for 10-20 years in the hospital, but now more acute young people are coming in. Women are in a small majority among the clients.

2. The best results have been achieved among middle aged women (40-70 years old). Also, men of similar age do well. Poorest results are among young acute schizophrenic clients, regardless of whether they are men or women.

3. During the first month many clients have difficulties in adapting to Sopimusvuori. About 20% of the newcomers just look around and go back to the hospital or to their parent's home (it is easier to leave, if you have a place to go). Those who do not stay are on the average in poorer condition and have more negative attitudes.

4. When a client has been in Sopimusvuori for over two years his chances of going back into the hospital are 1 in 10.

5. A minimum four year study gives the following results for the rehabilitation homes, which are the first step after the hospital

Rehabilitation Home	16%
Hospital	18%
Small Home	14%
Own Home (or parent's)	44%
Dead	3%
Other (no data)	5%

6. A matched comparison group selected from hospitals before Sopimusvuori was functioning shows that Sopimusvuori works especially well with patients who came from small local mental hospitals. Before 1972 there was practically no outlet for these patients. They stayed in the hospital until their death. They often got good care, but there were simply no places to put them.

7. In the early studies the behavioral ratings by the staff revealed little changes on the average during a two year follow-up, though those who went to the hospital got worse. Either the changes really are small and take time or the method does not reach them.

8. (Partial answer to the above). During three year follow-up the stability of the clients' condition is amazing. Re-test correlations in social skills, anxiety, assertiveness, activity are between .52 - .80 (staff ratings are lowers).

9. Positive changes are generally small and mainly in social skills. Clients' own evaluations change even less. The self-concept of clients seem to be very stable.

10. Staff and client ratings do not correlate much. Many clients either overestimate or underestimate their skills. The above results concern mainly the follow-up of clients. In my studies the atmosphere and functioning of the communities has also been measured using either participatory observation or rating scales. The next results are from these.

11. In 1976, Rudolf H. Moos' COPES was used in the day treatment center and the workshop. The staff saw these communities having more support, practicality, personal problem orientation, and aggression as well as less organization and control. Participatory observation confirmed also that the staff underestimated its control. During the early years staff control was thought to be against the principles of therapeutic community.

12. New rating scales adapted to our communities were made in 1979. Compared to hospital wards the rehabilitaiton homes were more democratic and organized as rated by the staff and clients. Now the staff rated their control realistically.

13. The rehabilitation homes are quite different in their atmosphere. Some are practical or control-oriented and some stress the ideas of the TC. The atmospheres are usually quite stable, though there are exceptions: one rehab. home has evolved from control and clarity to spontaneity and autonomy and back again to greater control.

14. The latest large studies show that Sopimusvuori has, according to the ratings of the staff, successfully avoided bureaucracy. Especially, hospital workers tend to complain about their working situation: no flexibility, too little information as not understand or support, etc. These complaints are rare in Sopimusvuori and also in other small organizations.

SUMMARY

Even in the beginning of the 1970's people working or associated with Sopimusvuori were quite pessimistic about changes in the care of long-term patients. Thousands of visitors came and went, some enthusiastic, some just watching this curiosity. Now we can see that we were too pessimistic. Two private organizations have been created in Helsinki and its vicinity. The mental health law allows all kinds of sensible alternatives now, and actually encourages these alternatives. Rehabilitation homes are planned or are already started in most of the 21 mental health districts. All this has happened in less than five years.

Does this turn out to be a real change? It is too early to answer, but one optimistic sign is the large project called "The National Program of Research, Treatment and Rehabilitation of Schizophrenia" in which over half of the districts participate in actively. in this project, the goal is to decrease mental hospital beds and to find working alternatives for long-term patients. This project was started in 1983 (its planning started three years earlier). The following early positive signs can be listed:

--- hospital beds have been closed

--- new alternatives have been found

--- a few impressive social skill programs have been created

— hospitals are renovating their wards and making them smaller

— planning of treatment programs in hospitals and in alternative care is emphasized.

Major problems remaining seem to be:

--- lack of sheltered work

--- overburdened mental health clinic and inadequate home-care

--- deficiencies in training of mental health workers

--- bureaucratic mental health system

What are the strong points of Sopimusvuori? Can the Spirit be analyzed? Here are some catchwords which describe the Spirit and Flesh of Sopimusvuori:

--- Small is beautiful

--- Don't lose your senses

--- Who else is responsible but you

--- Three does not make a crowd

--- Don't dig into your past failures

--- Let the heart rule more than the book

--- Never give up hope

--- Dirty hands do not lower your status

--- Plan ahead, but give room for spontaneity

--- Life is empty without parties.

Some of these descriptions are cryptic and need clarifying. People of Sopimusvuori feel now that there is not need to grow any more. Our Workshop is still growing but 300 beds or daily places is çthe limit. In most communities the number of clients is around 10-20. Only the sheltered workshop is markedly larger (60). The workshop has now some problems bake clients can withdraw quite easily and it is easier to skip or leave a larger group. Each client belongs to a small group, however, and this gives him support and security.

By senses we mean a practical mind. Usually there is a common sense solution to each problem. Often it helps, if you boldly take a hammer and nails, or pans and kettles, and start learning things with clients. There are no strict work roles for the staff. Hospital derived models must be discarded in Sopimusvuori. Common sense and dirty hands aim at normality to the greatest extent possible. Do as everyman does in his or her home.

Like many other communities we stress many-sided interactions. We don't have resources for dyadic therapy and became most clients have problems in groups, it is natural to stress the value of group- work. Clients are very vulnerable if they have not been able to form bonds and relationships.

We have an antipathy against patient papers and cards. We prefer not to have a patient's diagnosis and related hospital data available to us. In many places we do have a short questionnaire, which lets us know where the client is coming from, why he came, and what are his plans for the future. In the communities the clients are not encouraged to talk about their symptoms and past failures, because to do so would seem like an alibi or attention-getting.

In most communities there are strict rules against alcohol use, violence or smoking inside (fire hazard in old wooden buildings), but other rules come and go. In many communities life is quite spontaneous: food need not be ready at a certain hour. Small communities allow much flexibility. However, without planning, the communities would not have a clear view about the future. Norms and schedules give clients the structure they need. Schizophrenic patients do not usually stand much chaos and spontaneity.

Special occasions are very important for the communities. The society and communities use any plausible occasion to celebrate. Lately dinners in the finest hotel have been very popular, similarly travels abroad. Sopimusvuori has big parties during its yearly anniversary. Special days of each client are also celebrated.

Hope and responsibility are abstract words and difficult to achieve, but whenever a client can do something, he is allowed to do it, if possible. There have been many disappointments, but we consciously try to forget thoughts like "he has already tried unsuccessfully" or "she will not change no matter what you do." Hope can be aroused by small mastered steps, new friendships, and working for the common good. Slogans are used very little to bolster low self-esteem and hopelessness.

The work of Sopimusvuori is sometimes criticized because a clear theoretical base seems to be lacking. This critique hits the target. Sopimusvuori does not have a theory which could be a rationale for every day decisions or from which the program is planned. We have rather the "Spirit", a special work-evolved ideology. some of its features were listed above. Many of the members of the staff and supporters uphold the Christian ethos, and a great majority would co- sign Victor Frankl's ideas. Principles of therapeutic community fit here well, also.

Personally, I feel that there are not very good candidates for a çsuitable theory. Social learning principles are well suited to the beginning stages of rehabilitation, where staff control is natural. Here i mean programs of the type which utilize the token economy. The principles do not work if they are watered down. Some of the learning principles and can used in problem solving and social skills training, but I am not sure how much more can be achieved except with common sense.

Psychoanalytic or loosely psychodynamic theories are even of less value. Long term patients' abilities to discuss or gain insight are severely handicapped. Finding out early traumas is a completely wasted task. Similar, "soft" theories based on psychoanalysis, like transactional analysis, is of dubious value, too, though it might be easier to point out negative ways of interaction and show how to correct them.

Well functioning communities or programs seem to rely on either Spirit or Control or sometimes on both. Talking about theories is often preposterous. Effects of good programs are simply faith, authority (or control) and practice. All these seem to be working at Sopimusvuori. Here faith has to be understood broadly. Faith includes trust, expectations, involvement and hope. Both parties have to believe that the treatment is useful.

We believe there is potential in each patient or client. We believe that when a client behaves normally, it is because she is expected to do so. W know that he have gained useful knowledge working in our communities and thus have authority based on it. We have faith in our methods and we hope this faith become communicated to our clients. This is our theory, or rather our Spirit.

I am not speaking against theory. It is easy to describe what we want from good theory. They should be general, precise and simple (Thorngate, 1976), and have truth, beauty and justice (Lave & March, 1975), or simply theories should give us ability to predict and control. Unfortunately, Thorngate has persuasively argued that a social psychological theory cannot be at the same time, general, precise and simple. We have to give in somewhere. Principles of TC are general and perhaps simple, too, but not precise. Learning theories are often precise, but lacking either generality or simplicity.

Two features of our clients and patients seem to direct our selection of theory: homogeneity and stability . If our clients are very similar and their condition is stable, a precise theory can be used, but if they are dissimilar and unstable, only a general theory is possible.

Our clients are a heterogeneous group. A few are finding normal work for themselves and they can give up their pensions. Some barely manage with their symptoms and are able to achieve by working a weekly salary of 6 marks (one dollar). Some should be in the hospitals but we do not give them up so easily. A solution would be a selection of homogeneous clients in each community. Until now this is strongly opposed, though we have one place, where young people are usually directed. Thus, in these conditions, our theory can only be general: we are trusting our Spirit.

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A.R.E.B.A.-CASRIEL INSTITUTE: A DIFFERENT TC

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The title of this presentation is "AREBA-Casriel Institute A Different TC." AREBA stands for Accelerated Rehabilitation of Emotions, Behavior and Attitudes. In 1969, Dan Casriel founded the Casriel Institute and, together with Ron Broncato, AREBA. Both are located on West 57th Street in mid-town Manhattan.

A different TC may sound tautological since every TC is different from all others. I don't mean to imply that AREBA is unique among TCs. Casriel's therapeutic system, the New Identity Process, had been adopted by TC's all around the world. Nor is AREBA the only TC that treats a mixes population of drug abusers, alcoholics, young delinquents, anorectics, non-organic manic depressives and neurotics. Other TCs have decided on urban locations, and many, like us, are private, independent from the external control associated with public funding. The need to offer different kinds of programs for different clients has become increasingly a matter of common knowledge.

First, I will discuss the kinds of clients we deal with and why, then I will speak about our structure and therapeutic techniques.

We have applied for and hopefully will shortly obtain full certification and thus third party reimbursement. Till now, only a minority of insurance companies have agreed to reimburse our fees. Our program is therefore relatively expensive ($1,100 per week for first phase or intensive experience, $660 per week for second phase and $330 per week for third phase) In total the average cost for the c full program is approximately $40,000. The high cost of the program combined with the relative unavailability of insurance reimbursement has offered us a few advantages; mainly, however, it has presented us with challenges to which we have learned to respond.

The primary advantage is that the self-selection of our clientele allows us to work with people who are literate, many of who possess good verbal skills, and who come from an environment which is, at least socially, not too destructive. In addition, nearly all of our clients enjoy a significant level of family support and involvement. The chief challenge is that our clients, paying for their AREBA stays out of their own or their parents' pockets, often come to us having tried other therapies or programs that were free or at least less expensive, shorter in duration and less demanding. In more than 60% of the cases, we are asked to succeed where others have previously failed. Often, we are not even the second or third try, sometimes the eighth or ninth.

As we all know, when motivation and commitment are very strong, chances of success are high with almost any kind of treatment. Thus, accepting those who have already failed in another kind of treatment means working with a low-motivated clientele.

Why we treat a mixed population is more than a choice. It is part of our deepest heritage. Doctor Daniel Casriel founded the AREBA-Casriel Institute in 1969 after helping to establish Daytop Village, a prototype for publicly funded therapeutic communities for drug rehabilitation. He enhanced the successful Daytop Village methodology with new, more innovative approaches. At the same time, he created an atmosphere that would not be alien to the lifestyles and values of our patients. Another of Casriel's goals was to intensify and thus shorten the length of the program. AREBA, as I said before, shares its facility, on different floors, with the Casriel Institute which offers individual and group therapy to outpatients.

In the beginning, AREBA residents did not attend what we now call emotional groups. Then Casriel decided to allow a few residents to participate in evening out-patient groups. The results of the experiment were so exciting that after a while, more and more residents were participating in out-patient groups. The last step was to create daily in-patient groups and to fully integrate emotional work into the program.

At that point, some out-patients with non-drug related problems were admitted for what we still call the AREBA intensive experience. This consists of an initial period of two to six weeks of residential treatment, including attending two to three groups a day and participating in all family activities when not in a group. Obviously, the difference between the symptoms of this group and those of our typical patients necessitated a different therapeutic approach. On the other hand, we (and when I say we, I'm speaking of staff and residents together) could identify many similarities in the emotions and attitudes of these two different groups.

Our staff was and continues to be trained to work with the non-drug abusers among our clients. Those counselors who are graduates of AREBA or another program, who lack the background necessary for this task receive specific in-service training an supervision by the credentialed professionals who comprise one third of AREBA staff.

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Once a week, a full morning is dedicated by the staff to our ongoing meeting that can be structured either as a seminar or as a didactic group led by a therapist external to AREBA, who uses AREBA-like therapeutic techniques in this private practice.

Combining different kinds of clients obviously makes our work a bit more difficult, but offers certain advantages for the intensive patients and for the drug abusing population of AREBA. Through living with our long-term residents, sharing feelings, confronting eachother's attitudes and consequent behavior, our intensive patients learn that drugs are often just a different and more overt self-destructive answer to the same emotional disease. They learn that when not endogenous, their symptoms are interchangeable and that the way inadequacies are acted out can be a choice, which like other choices can be remade or corrected.

A person with symptoms which are not drug-related is often very self-indulgent. There is a wide cultural acceptance of the neurotic who claims he is not responsible for his behavior choices as if emotional disturbances would be the equivalent of a loss of free will. This person learns that his symptoms are just a different answer to similar problems faced by the drug abuser. If one places demands with love, concern, warmth, as well as the rigid consistency, it is possible for the patient to give up his symptoms, thus allowing him to re-evaluate his behavior.

For the drug abusing residents, on the other hand, the advantage lies mainly in the realization that staying clean may not be enough. They must learn why they turned to drugs, understanding that even people with no drug history can be unhappy until they deal with the underlying reasons for their disturbances.

As I just explained, AREBA has always had a mixed population and çits staff has always been trained to work with different kinds of patients. In the last few years, something else has evolved.

When Casriel and Broncato established AREBA, it was strictly for drug addicts and other infantile, non-functioning personalities. In other words, AREBA was for those whose lives were at stake and who were therefore ready to commit themselves to a long therapeutic process. In the past 15 years, unconventional therapies, such as the New Identity Process and the TC treatment modality have gained a wide acceptance, respect and attention. As a consequence of this cultural shift, more and more of our clients check into the full program not to save their lives, but to improve the quality of them. We have in-patients who were or who would be labeled in classical therapy as manic depressives, neurotics, anorectics, bulimics, etc., etc. These are people who could also benefit from non-residential treatment but who make the decision to devote a short period of time to work intensively in helping themselves.

The best example of this shift may be the family of six: divorced parents and four children, two of them heavily involved with drugs. One overdosed and died. The other came to AREBA, split, came back and split again, not responding to therapy. The other two children were not into drugs at all, both responded to the extremely painful family dynamics through withdrawal and depression; the girl also had food-related symptoms. Both were unsuccessful in other kinds of therapy. At different times, each decided to try AREBA. One graduated over a year ago and is now doing very well, the other will graduate shortly.

Research has proven that whites, and upper middle class drug abusers (the vast majority of our clientele), show more signs or ç psychopathology than other ethnic and class groups (you have to be sicker to break a stronger taboo). We also know that during treatment, many of them begin to show pathologies that were hidden by the self medication of their drug abuse. For the addict, the addiction is obviously the presenting symptom at the beginning of treatment. As treatment progresses, however, we recognize that the difference between the underlying problems of former addicts and so called "straights" is less significant than commonly believed.

In the last two years, we have also developed an intensive, short term treatment program specifically structured for the chemically dependent executive. Participants have professional, career and family responsibilities that necessitate a customized therapeutic and counseling approach. Patients begin with four to six weeks of intensive, in-patient involvement which includes detoxification, psychometrics, psychopharmacological evaluation, group and individual therapy, educational seminars and therapeutic community involvement.

Following this initial period, the clients return to their jobs on a full-time basis while continuing to reside at AREBA. Each evening, they engage in groups, meetings, seminars, and individual therapy focusing on actual life situations and work-related problems. Increased amounts of time are spent at home in order to resume their family roles. Family members are strongly encouraged to participate in weekly counseling sessions along with parents, spouses and sometimes even the children of our residents.

After four to six weeks, patients return home. They attend outpatient groups and receive individual therapy. Family counseling çontinues for approximately four to six months.

We have also developed a cocaine aftercare program for those who have recently experienced in-patient treatment in short term usually hospital based program or for those whom inpatient treatment may be unnecessary.

Our long-term program, like those of a majority of TCs is divided into three phases. The three phases total about one year generally with first phase occupying a bit less than 50% of the total. Although I'm sure

most of this audience is familiar with program structure, I'd like to briefly outline the AREBA structure. I'll try to explain this as best I can in the least amount of time.

In the first phase, the AREBA resident is immersed in a highly structured, supervised environment. The day consists of meetings, seminars, individual and group therapy sessions, and specific work responsibilities, the successful performance of which earns the resident privileges and higher levels of job responsibility within the program's structure. Throughout phase I, he is gradually exposed to the external world.

In the second phase, the resocialization process takes place on a full-time basis. A school aged resident returns to school. Others begin to work outside. The AREBA family member in second phase is involved in various group and individual therapies, mainly in the evening, as well as marathons and minithons on some weekends. He receives guidance in seeking out new friends and in fostering new kinds of relationships.

In the third phase, an individual continues in school or in his job. He lives outside the therapeutic community, often sharing an apartment with friends who have gone through the program. He still ç attends evening meetings, individual and group sessions. As he learns to adjust to the outside world, his involvement with AREBA gradually diminishes. After some months of living symptom-free and fun functioning socially and vocationally, at or near his potential, he graduates.

After graduation, we offer an optional post-graduate program. For a relatively small fee (equal to the cost of two weeks in first phase) the graduate has, for a period of 5 years, free access to all that we offer to our residents, including unlimited residential treatment, if needed.

This may sound like a guarantee of our product. In one sense, it is. We are a private company and we want people to know that we believe that what we produce is good. But even more than that, we want our graduates to feel free to ask for help when they need it without having to seek economic support from the family from whom we've taught them to be independent.

As I said earlier, our facility is located in mid-town Manhattan. This was not an easy choice to make. Since we are private, we are forced to pay for our building on the open market and I'm sure everyone here is familiar with the inflated real estate market in New York City.

For as much or even less, we could afford a beautiful estate in the country, complete with a pool, tennis court and other amenities. The air would be cleaner and our clients would probably be happier.

On the other hand, such an accommodation would shelter our residents from reality. It is our belief that they must begin to learn how to deal with reality at a relatively early stage of the çprogram.

We could have adopted the two facility solution to this problem of location which many other TCs have adopted. We could have had one facility in the country for the intensive initial stage of therapy and another in the city to be utilized by those residents in the later stages of resocialization.

We have chosen, however, to locate our program in the city and to operate all three phases in the same urban location.

The chief reason for this, aside from the unparalled availability of educational, vocational and cultural resources is our desire to keep our program short. Removing our clients completely from the outside world would require the luxury of a long period of readaptation. We also feel that such seclusion is unnecessary if there is close monitoring. We certainly know that our job would be a lot easier if we took more time. However, when it is possible to achieve the same result in a shorter time, we would rather choose that option.

As early as their second weekend in the program, our residents can earn the privilege to go out for an afternoon with other members of the AREBA family. After four to six weeks, by vote of their peers, they can be accorded the pocket money privilege. This privilege entitles them to $10.00 which we teach them to budget. We control the spending of this money by requiring them to obtain receipts for all money spent and to exhibit these receipts in a weekly meeting.

At this point, we send them out first with other residents and then by themselves for errands, medical appointments and to shop for personal needs with more and more money. Obviously every time they come home, they are seen by a staff member to whom they report ç thoughts, fears, temptations and any changes they experienced.

After the first few months of first phase, our residents earn a privilege which we call "socializing" which allows them to go out in the evening once or twice a week with at least one of their peers to clubs, discos and other public places. The goal is for them to meet positive people. After a screening session, people from the outside are allowed to date and establish relationships with our residents. By the time they get to second phase and are required to find jobs, they are generally self-confident enough to deal with their fears and to overcome them even though we are consistently encouraging them to acknowledge those same fears.

The reason we decided not to separate first from second phase different facilities is simple. Our second phasers are the best role models we could ever offer to our first phasers. Seeing people who have undergone

the same therapy to solve the same problems immeasurably helps our new residents to develop trust and confidence. We encourage them to go out together on their weekend requests. Once a week, they participate in the same confrontation groups; the sensitivity, understanding and leadership shown by those in second phase to younger members of the AREBA family, is carefully assessed as a measure of their growth.

We also think that this kind of interaction provides very positive reinforcement of the values learned in first phase. Sharing certain dynamics even on a part-time basis with our newer residents is a good way for those in phase two and three to remain in touch with the basic principles they previously learned.

On the other hand, we demand that those in first phase assert themselves and the values that we are teaching them. Since it is obviously more difficult to confront someone more advanced in the program than a peer, learning to do so is very beneficial. Assertiveness is an important area for the kind of population we are dealing with, many of whom come from hyper-protective family environments. The manner in which days are structured and the tools (verbal reprimands, slipbox, pullups, different meetings, etc. etc.) we use are more or less similar to the majority of TCs. I don't think there is any need to explore them in depth here, but I want to stress that since the inception of AREBA we have chosen never to employ headshaving, signwearing and other such techniques that in our judg- ment are unnecessary.

More interesting are the therapeutic techniques we do use. Casriel wrote about the New Identity Process that : "Despite the theoretical structure of my groups, I feel it is the process itself which is more important. The process involves more than sensitivity groups, more than encounters. I occasionally try new exercises and techniques, experiment with different group formats, add to the theoretical basis of the process new insights and crystallizations of old ones. Our group method is constantly changing".

Right now we have in AREBA eight different group leaders who run about twenty groups a week, covering the three phases, intensive, executive and out-patient programs. None of us runs a group in precisely the same manner as another. In addition, the input of the trainees who often assist us frequently adds something new.

Given the time allotted to this presentation, it is impossible to adequately describe a theoretical model of these groups. Anyone who is interested in learning more about this subject should attend the experimental workshop in the N.I.P. that is scheduled for the day after tomorrow.

I will therefore limit myself to illustrate what these emotional groups have in common. The goal is to help the patients get beyond their symptoms quickly to the feelings and attitudes that are their genesis.

Participants in our groups who have gone through the same experience as our newer residents are the ones who encourage newcomers to express their feelings honestly. They can easily spot any phony attempt to hide or disguise real feelings; they can offer support and understanding to anyone who places himself in a vulnerable position.

On the other hand they can confront and demand that the newer members transcend their fears and resistance (as they were able to do) when those fears become immobilizing and prevent deep and total sharing.

Sometimes we start a group with a session of "telling secrets". This is an easy task for those who have done it before and have felt accepted after expressing thoughts, feelings or fantasies that in the past, would not have been shared. For one who has never done this before, it is much more difficult but is made easier through the encouragement and example of others.

Obviously, getting to know each other on such a deep level helps to establish, in a matter of weeks, a quality of friendship and trust that takes years of acquaintance to develop in any conventional setting. These friendships may well be the most important basis of a successful program, as they are indispensable to the reconstitution of a superego and are the greatest help in overcoming moments of crisis, doubt or discouragement.

Helping our patients get in touch with feelings related to the past, almost always unexpressed and repressed for a long time, is the first necessary step. We then must help them to overcome the attitudes which they developed about their feelings, anger is dangerous, nothing should scare me, only wimps cry, etc., etc. Full bodied emotional expression in the form of screaming in fact facilitates our basic therapeutic goal.

The way we help patients to become comfortable with their feelings is by accepting all of them non-judgmentally.

While involved in this kind of emotional work, our patients are encouraged to "bond", i.e. to experience physical closeness and emotion openess concurrently. We do this by holding hand, hugging and nurturing. Merely talking about feelings doesn't make other people feel you. Screaming your anger or your fear, crying when in pain, hugging to give love and feeling pleasure while receiving this kind of attention is what breaks social, verbal, religious barriers, and as Casriel once wrote: "When the facade is stripped away, the feelings we all show are astonishingly similar". Becoming reassured that you are still lovable when you are angry, scared or in pain is the most effective way of clarifying negative behavioral patterns based on historical

expectations. In this way the patient can learn to adopt new behaviors, clearly identify their real needs and develop competences in meeting these needs.

The sum, total of all these points is a reflection of AREBA's long experience, our new ideas with which we have experimented, our mistakes that we learn from and corrected and the invaluable input of our professional staff and trainees who have come to us from throughout the world.

All of these sources enable us to offer a constantly evolving "product", not simply a copy of something else.

The philosophy that guides us can be summed up as follows: "when you offer the best that you can, there is no reason why everyone can't be helped to get better".

In an effort to make our program available to at least a few young people who do not come from privileged backgrounds, AREBA executive board created Daniel H. Casriel Memorial Scholarship which funds the treatment of worthy candidates who are in need. I would like also to announce a second scholarship fund to honor the memory of Robert Rathman, our resident director who died two weeks ago. He was an AREBA graduate who spent the last 4 years of his life giving back what he learned to many grateful men and women, including myself. It is also to his memory that I would like to dedicate this paper.

APPLICATIONS OF GESTALT THERAPY IN THE TC

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During the last ten years, Gestalt Therapy techniques have increasingly been incorporated into therapeutic communities, representing a relatively straightforward way of addressing some of the clinical dilemmas presented by a substance abuse population. This brief paper will describe some of those uses in preparation for a demonstration workshop at the conference.

Gestalt Therapy first became visible in the 1940's, when its founder, Frederick (Fritz) Perls began to depart from his training as an orthodox psychoanalyst. He devised new intervention strategies based more on phenomenological events than interpretive comments by the therapist. (Stevens, 1980). In developing his new therapeutic approach, Perls was strongly influenced by existential philosophy, with its emphasis on immediate experience; his experiences in theater and psychodrama; and body work as developed by Wilhelm Reich and others. Basic to Gestalt techniques is the notion that enhancing awareness promotes change, and the therapist's role is to facilitate that process. The techniques themselves rest on some very simple principles (Levitsky and Perls, 1970) and although these may initially seem far easier to understand than to utilize effectively, they can be added to a counselor's repertoire using concentrated but time limited training sessions.

An outstanding strength of Gestalt techniques is their usefulness in helping clients identify, describe, explore, and learn to appropriately express their feeling states. Historically, the more directly a particular therapeutic community was a descendent of the Synanon model, the more likely it was to foster the expression of emotion within a very narrow band of states. Synanon emphasized toughening up, functioning despite pain, converting feelings into activity. Confrontation or other expressions of anger were the only feeling states which were usually above suspicion. Sharing pain often was called self-pity; offering nurturance might be labeled as contracting; grieving viewed as self-indulgent. The softer, more tender areas, or emotionally complex themes, could not be explored in this setting (Deitch and Zweben, 1981).

Gestalt therapy is ideally suited to remedy these imbalances, and it is no accident that beginning about the middle 1970's it was increasingly incorporated into therapeutic communities. As programs gradually shifted their staffing pattern to include others of diverse backgrounds, who were not necessarily recovering addicts, other approaches began to filter in. This trend was largely welcomed by frustrated counselors who understood there were clinical tasks that they needed to do but did not know how to accomplish them. In addition, Gestalt work can produce some high drama, which was appealing, and its perceived anti-intellectual bias probably enhanced its acceptability as well.

Exploring Feelings: An Alternative to Confrontation

Most clients who have been involved with drugs for extended periods of time have some difficulties recognizing, describing, and expressing emotions appropriately. Those manifesting a pre-existing antisocial personality disorder will of course exhibit these characteristics, but they also commonly occur simply as a function of being caught in a drug dependence cycle for extended periods of time. It is so common for clients to immediately obliterate undesirable feelings that they need to learn or re-learn how to even recognize what they are experiencing. The Gestalt approach of asking the person simply to report what they notice or feel without trying to change it (referred to as monitoring the continuum of awareness), is powerfully effective in helping someone begin to explore his internal life. The therapist skilled in this process simply tracks or reflects without interpreting; the client learns to identify and describe internal states, vivid or subtle; the meta-message is that feelings just are; nothing needs to be done about them.

The continuum of awareness exercise can be done daily, with or without a facilitator. The payoff is enormous. By focusing in on the minute details of experience, the client learns to identify the subtle buildup of tensions which frequently lead to acting out behavior. This fosters the development of an "early warning system" and opens the possibility of choices in how feeling states are handled. Repeated work with the continuum of awareness will reveal what feeling states are the most difficult for the client to experience or report, and these can be given special attention. One of the major tasks in achieving a drug free life style is learning to deal with difficult feeling states, and this basic kind of therapeutic work offers a sound foundation.

Modifying Impulsivity

Certain Gestalt strategies can be effectively employed in individual or group sessions to work with the kind of situations which often lead to destructive acting out. In particular, the approach of asking a client to describe an event in the present tense, as if it were happening now, has wide applicability. Clients may be asked to describe in detail their experiences of craving, beginning hours or even days before an episode, as a means of identifying particular triggers of which the client may not be aware:

Cl: I am lying down in my room after work, and the next thing I knew I am on my way to the connection for some coke....

Th Let's go over it again. Relive your day for me, starting when you got home from work. Describe it in the present tense, as if it were happening now.

Cl: Well, I get home and I am feeling lousy.

Th: Lousy? Can you describe that for me, what it was that you are calling "lousy"?

Cl: Well, my wife is getting on my nerves, and I feel no one understands what I am trying to do in my life now, and I think about the buddies from the job I left and wonder how they are doing .....

Thus the therapist can help the client differentiate and begin to label various feeling states, in this case irritation, frustration, loneliness, and sadness. These can be later observed for their role in triggering drug hunger.

Not all episodes of craving have an identifiable trigger, and Gestalt therapy can be used to help clients master the experience and view it with some perspective as an experience which will pass. Just as the reader may readily produce salivation by imagining the smell, taste and feel of a juicy lemon, clients can show visible signs of arousal when reliving episodes in which they used or were tempted to use. The client may then be asked to describe, as if it were happening now, how he would like to handle that situation. The therapist instructs the client to take his time, imagine the events as vividly as possible, and report both actions and feelings. Active mastery through rehearsal in fantasy is a tool humans employ from early childhood on, and Gestalt techniques allow us to show clients how to use it both in sessions with a counselor or on their own. This tool is a great addition to other structured techniques in work on relapse prevention.

Dealing with Externalization

A fundamental tenet of Gestalt therapy is that the client changes by reclaiming the cast off parts of the self, and almost all the techniques facilitate this goal. Reliving experiences as if they were happening in the present tense enables the client to clarify choice points in the acting out process. Translating behaviors into interpersonal statements allows the client to examine the consequences of behaviors. For example, clients may translate the act of coming late to meetings in a variety of different ways:

"I'll do it on my timetable, not yours."

"I can't bear to sit around waiting for anyone."

"My time is more important than yours; you wait for me."

"I'm helpless to get here on time, need you to take charge of my time."

"I can't be expected to do as everyone else. I'm special."

Externalizations which take the form of selecting another in the community to act out the hidden parts of the self can be handled by asking the client to play out both sides of the conflict. For example, Jim and Jane repeatedly get into ritual bickering in groups, and no amount of confrontation in the group is able to resolve their impasse. Asking Jim to play both himself and Jane allows him to see the disowned part of himself which she represents, and once the issue is explored in these terms, the relationship between warring parties generally changes.

"One Day at a Time"

Gestalt work can be used to add deeper dimensions to the recovery philosophy of taking one day at a time. Frequently clients outrace themselves and react on the basis of what they fear will occur, rather than what they are in fact experiencing. Often it is not their actual discomfort, but their fear that it will become unbearable, that prevents them from working issues through productively. Repeatedly asking clients to compare what they are actually feeling with what they are imagining or fearing will happen gives them a much firmer reality basis on which to proceed.

Training Staff in Gestalt Techniques

The theoretical underpinnings of Gestalt techniques are very simple and very few, but mastering them can take varying lengths of time. They are easy to understand and sometimes hard to do. Imperfect understanding leads to the kind of mechanical application frequently seen during the 1970's when Gestalt enjoyed peak popularity. Currently, Gestalt Therapy has reached a level of maturity and is routinely offered in many graduate training programs. Institutes exist all over the United States and in Europe. A clinically experienced (though not necessarily credentialed) staff can learn much that is useful if weekly training sessions are provided for a period of 6-12 months. Supervision utilizing role plays are a key factor, as it is by definition a therapy that must be learned by experience. Participation as a client is of course desirable, but not always possible. Such engagement may be exceptionally useful for recovering staff with several years

abstinence, as they are frequently very group-wise and skilled at handling interpersonal confrontation. For them, Gestalt opens up new possibilities for inner exploration.

In summary, Gestalt techniques offer a rich source of therapeutic interventions very well suited to the specific needs of recovering clients. They can be taught relatively easily to counselors with a wide range of professional training, provided the appropriate time commitments are made. They are a natural complement to interpersonal confrontation techniques are useful for a wide range of therapeutic tasks.

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